1-1-1996

Psychosocial community education and war trauma : conceptual issues and case of Central American mental health workers.

Mishy, Lesser
University of Massachusetts Amherst

PSYCHOSOCIAL COMMUNITY EDUCATION AND WAR TRAUMA: CONCEPTUAL ISSUES AND CASE OF CENTRAL AMERICAN MENTAL HEALTH WORKERS

A Dissertation Presented

by

MISHY LESSER

Submitted to the Graduate School of the
University of Massachusetts Amherst in partial fulfillment
of the requirements for the degree of

DOCTOR OF EDUCATION

September 1996

Education

PSYCHOSOCIAL COMMUNITY EDUCATION AND WAR TRAUMA: CONCEPTUAL ISSUES AND CASE OF CENTRAL AMERICAN MENTAL HEALTH WORKERS

A Dissertation Presented

by

MISHY LESSER

Approved as to style and content by:

David C. Kinsey, Chair

Robert J. Miltz, Member

Ervin Staub, Member

Bailey W. Jackson
Dean, School of Education

DEDICATION

This Dissertation is dedicated to
my life partner Bruce, whose love and understanding provide for me daily,
my mother Nettie, whose unwavering support, generosity and devotion are my model,
the memory of my father Irwin, who should have been here to enjoy it all,

and

the hundreds of women and men from Latin America
whose pain has touched my own
and whose courage, hope and belief in healing
have been my nourishment
and inspiration.

ACKNOWLEDGMENTS

My gratitude casts a wide net that covers continents. My deep appreciation goes to the Central American community mental health workers whose struggles and achievements provide the basis for this study. To protect their identity, I am unable to name and appreciate them as individuals. A photograph of the group graces my windowsill and has overseen the writing of this study. It frustrates me that thus far I have been unable to share the results of this study with them.

I am grateful to the Center for International Education for lending itself to me as a safe and flexible container for the exploration of the issues addressed in this dissertation. My debt extends to Don Graybill for having introduced me to the Center, to Anna Donovan for her unswerving support, warmth, and perpetual welcome. I am most fortunate to have had the opportunity to work with David Kinsey as my chairperson. His keen mind, careful and caring attention, gentle yet steadfast prodding, and exceptional skill at conceptualization fill me with inspiration, and gave me the encouragement I needed to wander between praxis and theory until this dissertation was ready to be hatched. The wise and supportive guidance of committee members Robert Miltz and Ervin Staub have been invaluable to me. Their timely, thoughtful recommendations, good-natured spirit, sense of humor and sense of the significance of it all have made this a mostly enjoyable process. I am also grateful to the students and faculty I was fortunate enough to study with. Special thanks to Phyllis Robinson for conversations shared, articles swapped, and continual thoughtfulness. From the Center I ventured out into the now-defunct family therapy program where under the superb guidance of Janine Roberts, I was able to unearth the elements that would add to my cross-fertilization of education and therapy. My thanks to Janine for being an exceptional mentor.

Many people at the Institute for Training and Development (ITD) of Amherst, Massachusetts have shared their pathway of participatory education with me for the past five years. Under the leadership of Linda Abrams, Dan Moulton and Don Graybill, I came to trust myself more as an educator, which allowed me to break new ground in my work. My ITD co-workers over the years have been some of my greatest teachers. In particular, I want to acknowledge the talent and abilities of Flavia Ramos, Edgardo Rothkegel, Tom Gothers, Alice Maldonado, and Kathy Searle. I am immeasurably indebted to them in more ways than can be enumerated.

To Diane Johnson, my praise and gratitude for meticulous, timely, and gifted editing. Her steadfast encouragement and friendship helped dissolve what at times felt like the excruciating isolation of writing. To Wendy Elliott, Nancy Knudsen, Sara Schley, ALisa Starkweather, Paula Green, Esperanza Martell, and Roxana Paiz, my special thanks for devoted friendship and inspired suggestions at just the right moment, confirming my belief in divine guidance. To Sharon Weizenbaum and Martha Braun, my gratitude for support rendered to the participants during the case study, and exceptional talents that helped guide me back to health after it ended. I acknowledge with appreciation Tom Herman's outstanding healing abilities that taught me about the need for self-care at a deeper level. I extend enormous gratitude to my mother Nettie, sister Carol, aunt Eve and cousin Bonnie for boundless generosity and loving kindness that sustained me throughout the doctoral process and beyond. I am indebted to my husband Bruce and step-daughter Karina for timely technical and moral support at the computer.

To the people I have worked with from the shantytowns of Chile and villages of Ecuador, and all the hundreds of participants from Central America and the Andean countries who I have been privileged to know, my great thanks for revealing the pathway between mind, heart and spirit. It has become the road most traveled in my work and life.

ABSTRACT

PSYCHOSOCIAL COMMUNITY EDUCATION
AND WAR TRAUMA:
CONCEPTUAL ISSUES AND CASE OF
CENTRAL AMERICAN
MENTAL HEALTH WORKERS

SEPTEMBER 1996

MISHY LESSER, B.A., CITY UNIVERSITY OF NEW YORK
M.A., FLACSO-ECUADOR
Ed.D., UNIVERSITY OF MASSACHUSETTS AMHERST

Directed by: Professor David C. Kinsey

Increasingly, war and armed conflict are having devastating effects on the psychological and social well-being of civilian survivors throughout the world. There is a serious shortage of practitioners and culturally-appropriate models for assisting victims of psychological trauma with their healing and recovery. Educational settings, be they formal or nonformal, are appropriate places for psychotherapeutic interventions. This dissertation focuses on the intentional use of a nonformal educational setting for psychosocial healing of those exposed to war-induced trauma. A participatory education program designed to teach Central American community mental health workers the basic concepts and techniques of trauma treatment also served as a healing environment for the trainees. Individual psychological trauma as well as war-related intra-group conflict were addressed. Using an integrative model of healing and recovery, the intervention combined cognitive, emotional, spiritual, social, and physical approaches. The educational setting provided a larger interactional framework for the social contextualization of intrapsychic wounds, thus supporting healing. The case illustrates the importance of self-care for professionals and para-professionals working with the psychologically traumatized, which is rarely mentioned in the literature.

This is a qualitative study that combines a literature review on the nature of trauma and recovery, a case study with Central American community mental health workers, interviews with practitioners, and personal experience. The literature review takes into consideration cultural and Latin American perspectives, the importance of community-based approaches, and the linkage of individual and social dimensions. It includes a critique of posttraumatic stress disorder as a conceptual framework. The inquiry examines the viability of intentional incorporation of psychosocial healing into an educational setting, and indicates which components of participatory nonformal education best lend themselves to interfacing with psychological healing. Findings from both the literature and case study point to a need to question long-held assumptions of psychotherapy when working with trauma survivors. Self-care, safe container-building, peer support, mentoring, and a heightened role for para-professionals are recommended. The training and preparation of community mental health workers is seen as an effective response to the proliferation of war-related trauma.

TABLE OF CONTENTS

PART 3 CONCLUSIONS

GLOSSARY

Educator/therapeutic guides: those who design and deliver programs that intentionally integrate psychosocial healing into educational settings, and can address the cognitive, emotional, spiritual, social, and physical dimensions of the human need for healing; the use of the term 'guide' is borrowed from psychosynthesis, which defines guides as those who help others bring to life their fullest potential, so as to advance the health and potentials of humanity (see Brown, 1983).

Psychosocial: interface between psychological and social phenomena and processes; how the psychological and social aspects of human reality inform one another.

Socioeducation: education that prioritizes the exploration and explanation of the impact of social forces and social context on a given phenomena.

Participatory nonformal education: learning process that generally takes place outside the confines of school-based regimen, is experientially-based in that it values and validates individual experience as bearer of a piece of the truth of social reality; fosters empowerment, and encourages critical consciousness of the role of social context in the definition of individual and group challenges.

Formal education: school-based learning process; has traditionally been based on the premise that learners are recipients of knowledge more than contributors to its creation.

Critical consciousness: theory that encourages awareness of how individuals and groups are socialized into the belief system, values, and behaviors of the dominant culture; fosters the taking of action as well as the development of consciousness.

Metaskills: the attitude that lies behind and motivates the application of skills, for example, compassion, the ability to suffer with, to support all sides in a conflict, to show respect for all opinions, to hold an unwavering belief in the human ability to heal.

Brainstorm: training technique whereby on a given topic, participants contribute concrete and concise ideas while facilitators or educators make note of them, generally on a flip-chart; discussion of specific ideas is discouraged until everyone has had the opportunity to offer their thoughts; an excellent and highly effective tool for eliciting individual opinions and revealing the degree of similarity or disparity between them in a group setting.

Container-building: intentional creation of shared group identity and purpose in order to support group members in risk-taking, personal work, self-disclosure, offering effective feedback, conflict resolution and other forms of healing.

INTRODUCTION

The Nature of the Problem

Civilians are being ravaged by war and institutionalized violence in increasing numbers in some fifty countries throughout the world. Currently, some 90 percent of those killed in armed conflicts are civilians, the majority of whom are women and children (UNICEF, 1992). The destruction of whole communities is symptomatic of a kind of warfare that aims to destroy human population, perhaps more than control geographic territory. Typically the poorest sectors of society are targeted and terrorized. It seems inevitable that armed conflict and war damage the social and cultural institutions that sustain life (Summerfield, 1995).

Much of the violence of contemporary warfare is protracted in nature, hurling into the world a generation of children and young adults who have known no other life. Often survivors dizzied by the sheer terror of what they have been exposed to, are burying their dead while tending to those physically and psychologically more wounded than they themselves. It is frequently the case that surviving communities are sunk into seemingly irreversible hostility, leaving no one untainted in the damaging passage of human devastation. Usually it is the traumatized who are assisting the traumatized in the daunting work of healing and recovery.

There is a serious scarcity of mental health and educational practitioners, both professional and para-professional, equipped and willing to lend support to those hurt by the campaigns of terror engulfing children as well as adult survivors, many of whom live in rural communities and villages. Compounding this already highly stressed situation, there is a lack of consensus among mental health practitioners regarding optimal approach to care-giving. Disparate interpretations of the very nature of psychological trauma, characteristics of the healing process and healing relationship, as well as differences between the respective cultural frames of practitioners and survivors are perched at the center of an ongoing discussion. There is a noticeable shortage of mental health and

educational practices and approaches that are culturally derived from and aligned with the needs and situations of the different groups and communities affected by war and violence.

In Latin America the lives of millions of people have coexisted with overt war, institutionalized violence, and social injustice during significant periods of the past five centuries. A plethora of unhealed psychological wounds are partially reflected in precarious democracies and weakened communities characterized by distrust and intolerance. As in much of the rest of the world, the wounding of the hearts, minds, and bodies of many of Latin America's peoples dampens the possibilities of ensuring viable and sustainable societies.

This dissertation organizes a conversation about the nature of psychological traumatization and whether an educational setting can be intentionally used for the purposes of personal and social healing. Examples are drawn primarily from Latin America, with emphasis on a psychosocio-educational case study conducted with village mental health workers from Central America.

The Need for the Study

In a variety of educational settings, be they formal or nonformal, the presence of violence-induced psychological trauma among learners is widespread in many regions of the world. According to UNICEF (1993), up to twenty percent of all children live in difficult circumstances, which include situations of armed conflict, abandonment, abuse, and child labor. Those fortunate to have schools to attend are impaired due to the impact of psychological trauma on their growth and development. The healing of these children is intimately tied into the healing and well-being of their adult caretakers.

Despite the opportunity for recovery they afford, there is scarce evidence in the psychological, educational, social science or medical anthropology literature of the use of educational settings for the

intentional healing of war trauma in adults. A few researchers and practitioners have developed innovative and effective approaches to preparing and orienting teachers and adult caregivers to identify the signs of trauma in children, and to helping them cope with the stresses of war (Macksoud, 1993; Baron, 1994a, 1994b; Lykes, 1992, 1994). But few approaches have been designed that assist adults in a nonformal educational setting with recovery from the crushing experiences of war and violence. It is the premise of this study that community-based psycho-socioeducational efforts offer a realistic opportunity to help relieve and heal the ongoing pain of those exposed to war and violence.

Complex reasons may explain this shortage of studies on the use of community educational settings for psychotherapeutic healing. First, mental health providers and researchers often come from and/or circumscribe themselves to urban settings and have scant personal or professional experience in rural areas where populations are often hardest hit by armed conflict (USAID-El Salvador, 1993). Second, community-based educational efforts, while reaching rural villages, are often designed and facilitated by people with little or no training in the mental health field, leaving them hard pressed to respond to individual or group needs for trauma treatment. While there may be relatively little evidence of research on educational and therapeutic endeavors to heal psychological trauma at the community level, there is an abundance of clinical writing about the nature of the human response to trauma, and a variety of models for the assessment and rehabilitation of those exposed to it.

In Latin America war has existed alongside of institutionalized violence, particularly against women, the poor, and racially and culturally oppressed peoples. Countless social movements have been born and reborn despite unrelenting repression. These social movements, based in urban shantytowns, rural villages, farms, universities and the workplace have spawned a sturdy tradition of grass-roots organizations that have gravitated toward and been forged, to some degree, by decades of participatory education. Community members and leaders from much of Latin America have grown up on a steady diet of workshops and seminars

fostering critical thinking by covering a wide variety of topics and issues, from political and economic history, to communications skills, and leadership development. Latin America is birthplace to 'education for critical consciousness' (Freire, 1973), that combines a dialogical approach to change, critical reflection, and transformation through social action, in the context of a participatory educational setting. It is partly upon this heritage that the focus of this dissertation rests.

In addition, unlike some regions of the world where working with a psychotherapist can result in personal marginalization (Japan, for example), the practice of various schools of psychiatric care in much of Latin America has made the presence of psychologists and social workers a familiar one in the lives of millions of people, and not just those who can afford private services. In Chile, Argentina, Uruguay, Peru, El Salvador, Guatemala, and Brazil (all countries that have experienced government-sponsored terrorism and significant social violence), psychotherapists play an active role in the treatment of and advocacy for those wounded by the many faces of war and conflict.

By relying on a case study conducted with village mental health workers from Central America who identified with opposing sides of their country's armed conflict, this dissertation organizes a conversation between educators and therapists about the nature of psychological trauma and its treatment.

Purpose

This study examines how an educational setting can lend itself to the psychological healing of those exposed to war and violence. It also addresses the issue of para-professional involvement in the recovery process of traumatized civilians. Using Latin America as general context and a field trial with Central American mental health workers as specific point of reference, I will explore the content and methodology of an educational endeavor that invites psychotherapeutic intervention to aid in the recovery of those suffering from psychological trauma. A literature

review and select interviews will contribute to the exploration of how education and psychotherapy can be intertwined to assist survivors of war and violence.

The purposes of the inquiry are:

- to investigate the viability of intentional incorporation of psychotherapeutic healing into an educational setting;
- to discover the components of participatory nonformal education that best lend themselves to interfacing with psychological healing;
- to disentangle the key elements of safe container-building for psychological and social healing in group-based educational settings;
- to identify working hypotheses for the creation of a group experience that supports healing.

These are the important questions that will be answered in the course of the study:

1) Can para-professionals be prepared in an educational setting to provide support to community members suffering from psychological trauma? If so, what are the key ingredients of this preparation?

2) In what ways will an educational/psychotherapeutic approach to healing war trauma differ from its component fields of nonformal education and psychotherapy?

3) How can an educational/psychotherapeutic intervention address the whole person, that is, the physical, psychic, spiritual, emotional, social, and cultural aspects of human life?

These questions will be answered by examining the literature, analyzing the results of the field trial study with Central American mental health workers, interviewing educators and psychotherapy practitioners, and reflecting on my own personal experience.

Background to the Study

My personal encounter with war and organized violence began in Latin America, specifically Chile, when sectors of the armed forces overthrew the democratically-elected government of Salvador Allende in a brutal and merciless coup d'etat in 1973. I was twenty at the time and had been living in Chile for over two years. My work was as a volunteer in urban shanty-towns, supporting the burgeoning community organizations that flourished during the short-lived and socially-vibrant Allende government. The primary focus of my activity was with women and youth in the area of community education.

The September 1973 coup d'etat found me in Chile, culturally and intellectually unprepared for the implications of a military takeover, and with a strong sense of loyalty to those I worked with, particularly at this moment of their great vulnerability. Supporters of the Allende government and community activists of many persuasions were being systematically rounded up, imprisoned, summarily executed, disappeared, or tortured to death. The fortuitous combination of help and good fortune allowed me to leave Chile after a month in hiding, physically unharmed but emotionally shattered. I dedicated the next ten years of my life to human rights work on behalf of Chilean political prisoners, working as a public educator about the role of the United States in the design and execution of the coup d'etat, and promoting international solidarity work to support the Chilean people in their resistance to the military dictatorship. These ten years were spent primarily in the presence of Chilean exiles, some of whom, as former political prisoners, were allowed to enter the United States. This was part of a symbolic, albeit grossly insufficient, gesture on the part of the U.S. government to demonstrate concern for human rights violations in Chile in the aftermath of a coup d'etat that it engineered.

The organizational and political culture that I participated in during the decade following the coup d'etat was characterized by a combination of overwhelming yet frozen grief, survivor guilt, and a steady dosage of

stoicism. Each time one of my colleagues was killed or imprisoned in Chile, I worked harder to topple the dictatorship, all the while unaware of how the things I had experienced in Chile were numbing me emotionally.

It was not until my doctoral studies guided me to the field of family therapy that I came upon the diagnostic criteria for posttraumatic stress disorder as defined by the American Psychiatric Association. I then realized that the five months of sleeplessness I endured following the coup d'etat had their rhyme and reason, and that my startle response particularly to loud noises and helicopters could be traced back to my nights in hiding on the outskirts of a Santiago shantytown.

This personal discovery led me to ponder the larger implications of unacknowledged psychological trauma. An entire generation of Latin American social and political activists had perished physically or been ravaged emotionally without being able to name or heal their grief. Entire communities were destroyed and thousands of people had been hurled into exile. In my work as an educator with community leaders from several Latin American countries I began to notice a multiplicity of indicators that many people were attempting to function 'normally' while carrying monumental feelings of hopelessness. After designing and delivering several educational programs for women leaders (mostly from Central America), I began to discern several patterns that allowed me to recognize the existence of a great storehouse of suffering calling out for release through individual and group healing. Therein lies the beginning of my efforts to fold aspects of psychotherapeutic healing into educational endeavors.

One of the difficulties inherent in the creation of this intellectual and therapeutic brew has been the lack of models, both theoretical and practical. At first I asked, is it overstepping my bounds as an educator to acknowledge and work with the emotions expressed by participants in a workshop or training program? The oftentimes unrelenting tears, particularly of women exposed to multiple trauma, did much to answer that question. It was unavoidable. I would have had to completely retool

and reroute my training designs, educational strategies and personality to avoid the issues that unleashed the grief that seemed to pour into the training setting. I soon realized that my work was hovering in a place I felt ill-equipped to name–somewhere between the cognitive, emotional, social and spiritual worlds.

Interestingly enough, as my commitment to the combining of social change and personal growth expanded, I discovered new ways of designing and delivering interventions that integrated healing and education. Participants from Latin America responded well, perhaps because of increased challenges they faced in their countries, and their dissatisfaction with educational interventions that failed to anchor themselves in their personal and collective experiences. By examining with participants the interface of individual and cultural belief systems, personal and group attitudes, and institutional patterns, I gained insight into the great potential that sits perched within this orchestration of psycho-socioeducational approaches.

As participants discovered how their personal attitudes and behaviors were informed by cultural guidelines and mental models, it seemed that their commitment to personal growth work and collective problem analysis increased. The cognitive and the emotional began to move toward one another, as participants connected newly acquired insights to their hearts. This became clearer to me when working with women around issues of self-esteem. Their initial need in rendering personal testimony consistently outweighed their interest in theoretical or historic explanation of gender oppression, although this was appreciated and incorporated into their reflections and group discussions once personal testimony was introduced. Through personal sharing women addressed their desire to break isolation and overcome shame. Once their hidden and disavowed stories were unearthed and examined collectively, a commonality of experience could be established. Then their thirst for information and knowledge about the origins of gender oppression and socialization became insatiable. This led into a group-based process of theory-building. At this point the line between education and emotional

healing began to fade for me, and although it is still somewhat blurry, the undertaking of this dissertation has facilitated the emergence of clearer contours through the fog.

Several years of work as a community educator, guided by the Latin American heritage of nonformal participatory education, culminated in my involvement as curriculum director and lead trainer for an eight-week educational program with a group of twenty-four village-based mental health workers from Central America. The program took place in the United States, under the careful and thoughtful guidance of the Institute for Training and Development of Amherst, Massachusetts. The mental health workers received scholarships through a Congressionally-mandated program to provide Latin American community leaders with opportunities to study and live in the United States. In this case, the mandate was to provide training in community mental health and leadership development. The case study results contained and analyzed in this text are based upon that work.

My own process of self-awareness around psychological trauma has been inspired and heightened by the survivors I have been fortunate to work with. Any clarity reached or contribution made to the field is attributable to their trust in and commitment to healing the collective heart and mind of humanity.

Methodology

This is a qualitative research study that grew out of professional work and personal experiences in Latin America. Heuristic in nature, it serves as an aid to understanding the phenomenon under study, namely the intentional incorporation of psychological and social healing into an educational setting. In the course of my professional work, I came face to face with the reality of psychological trauma as experienced by a high proportion of Latin American community leaders who were exposed to war and violence. While still uncertain about whether or how to address this in the context of an educational intervention, my first efforts were tentative and experimental. Initially, issues of pace, order, intensity,

safety, and personal choice were explored. That experience informed my participant observation, data-gathering and the analysis contained within this body of work.

The dissertation study includes the combination of a critical review of the literature on psychological trauma, an experimental field trial with Central American mental health para-professionals, personal reflection on the viability of the combined educational/therapeutic interventions, and interviews. Interview subjects were psychotherapists with education experience. An interview format was developed for this purpose (see Appendix B).

The case study is based on participant observation of an educational intervention with twenty-four village-based mental health workers from one of the Central American republics, many of whom witnessed intense combat during prolonged periods of armed conflict in their country. The focus for the case report is thematic (Merriman, 1993), in that theoretical formulations have surfaced from the case study analysis. The theme that runs through the study is the applicability of combined psychosocial educational interventions for the healing of war trauma. Human subjects are protected through the use of pseudonyms. Unfortunately, no follow-up study has been done with the human subjects. Although this doesn't detract from the trustworthiness of this inquiry, I believe a longitudinal study would help uncover additional interactions of educational and psychotherapeutic factors and useful interpretations.

Field notes reflect the complexity of my role as researcher, both as participant observer, and as informant of my personal encounter with and response to the vast storehouse of pain released by the participants during this psychosocial educational intervention. These reflections have been useful guides to me in the healing of the secondary trauma I experienced as a result of my participation in this intervention. Emerging concepts from the field trial were, in some cases, channeled back into the intervention for the purpose of fine-tuning the educational methodology and psychotherapeutic interventions.

The psychiatric, medical anthropology, feminist, and Latin American psychotherapeutic literature are sources for examining the origins and nature of psychological trauma, and strategies for recovery and healing. The literature review did not inform the case study or definition of the problem, nor has it been my intention to use the case study in order to critique the literature. In this dissertation the literature has been scanned in order to glean elements that can contribute to an understanding of the lessons learned from the case study.

As investigator, my biases have been explained in the preceding 'Background to Study' section. I was never a detached observer or disinterested participant in this process. As a survivor of political repression, I harbor an awareness of the social origins of violence, and the beliefs, behaviors, and norms that perpetrate violence. At the same time, my personal experience and philosophical orientation have convinced me of the possibilities of collective human healing. These views were shared with the participants in the case study at the outset of the intervention. No doubt, my biases influence the meaning I attribute to people's attitudes and behaviors, and the hopefulness I attach to individual or collective steps toward greater self-knowing and personal transformation.

As a means of addressing my own subjectivity and trying to insure the trustworthiness of the study, I used my field note entries for self-assessment. It was particularly useful for me to notice my own responses to participant openness or resistance to change, and acceptance or hostility toward one another. I tried to make a record of any expectations I had about participant behaviors, and my own frustration with continued animosities among them. Mindful of how my own attachment to outcome (in this case, reconciliation) could inform my interpretation of the study, I tried to separate out my own desires from the data itself. I also used the field notes to better recognize my responses to the group's inter-personal dynamics. I often did this in conjunction with the observation charts (see Appendix A).

Structure and Content of Study

Part 1 (Views from the Literature) contains two chapters. Chapter One examines the literature on the nature of psychological trauma and various human responses to it. Chapter Two focuses on strategies for recovery and treatment. Most interesting are insights gained from the psychiatric, medical anthropology, feminist, and Latin American literature that are applicable to the design of psychosocial educational interventions. Particular contributions from various bodies of knowledge offer tools to paint the broad strokes of a viable psychosocial community education approach.

In Part 2 (A Case of Combining Educational and Therapeutic Endeavors), comprised of two chapters, the results of the case study are presented. Chapter Three provides the background information and the curricular design of the case study. Characteristics of the participants, learning objectives, techniques, exercises and educational/therapeutic strategies are introduced. Chapter Four narrates the unfolding of the educational/therapeutic process, with particular emphasis on conflict resolution facets including individual and group-based change moments. The emergence of unofficial curriculums to address both the intra-group conflict and the staggering psychological pain of some of the participants is described, as is their interface with the official curriculum. It also identifies the key issues and lessons learned from the case study.

Chapters Five and Six make up Part 3 (Conclusions). A discussion of findings on the nature of trauma and healing, and the viability of psychosocial educational interventions is presented in Chapter Five. The intersections between the literature review, case study, personal reflection and interviews are examined. Chapter Six offers general orientations for psychosocial educational interventions. Guidelines for self-care and the care of educator/therapeutic guides are offered. Areas for further inquiry are identified, such as the role of intra-group conflict in group-based healing, the role of para-professionals, and the impact of culture on psychological traumatization.

PART 1
VIEWS FROM THE LITERATURE

INTRODUCTION

The following literature review is based on an examination of sources from the psychiatric, medical anthropology, feminist, and Latin American psychosocial literature on the nature and treatment of psychological trauma. The extant body of scholarly literature on psychological trauma is vast in quantity and varied in approach, making a thorough examination of the multitude of models and theories of psychological trauma beyond the scope of this dissertation. Ever mindful of my purpose to benefit the design of psychosocial educational interventions for para-professionals committed to working with victimized groups, the cited literature focuses on the nature of trauma, the variety of human responses to traumatic stressors, and strategies for recovery. More specifically the literature search reveals insights and data that inform educator/therapeutic guides about trauma and recovery strategies for their multi-layered task of:

1) protecting themselves from secondary trauma and teaching para-professionals how to do the same when working with victimized groups;

2) gaining knowledge about the various human responses to trauma in order to share content information with para-professionals;

3) working with para-professionals to heal their own psychological trauma responses;

4) preparing para-professionals to support the healing process of trauma survivors and victimized groups in their communities.

Chapter One begins with a discussion of various interpretations of the nature of psychological trauma, its causes and manifestations. A brief

overview of the numerous theoretical models and perspectives is presented, followed by an analysis of the emergence of posttraumatic stress disorder as a diagnostic category sanctioned by the American Psychiatric Association. The various human responses to traumatic exposure, the healing relationship, and the dangers of secondary trauma are also explored.

CHAPTER 1
THE NATURE OF PSYCHOLOGICAL TRAUMA

1.1 Psychological Trauma and Its Causes

There is no single accepted definition of psychological trauma. Rather, a multiplicity of explanations and approaches coexist in the mental health field. Is psychological trauma the sum total of the symptoms it evokes and the diagnostic features that represent them, the structural changes in the victim's brain upon exposure to overwhelmingly frightening events "outside the range of usual human experience" (DSM-III, 1980; DSM-III-R, 1987), or a normal reaction to abnormal circumstances rooted in society's disorders (Brown & Shanahan, in press; Corvalán, 1990; Becker, 1995)? The threads of this ongoing discussion among mental health practitioners have been well worn (Kolb, 1993), and may eventually be tied off as the answer rapidly appears to include all these explanations.

Seen in its simplest terms, psychological traumatization is the human biological and emotional response to terrifying experiences that would be distressing to almost anyone. At a biological level, neuro-chemical changes take place in the brain that can damage brain cells, causing trauma survivors to reexperience the traumatic event in the form of thoughts, memories, dreams, flashbacks, and/or dissociative episodes. This reexperiencing is often accompanied by a tendency to avoid those triggers that recall the traumatic event–whether they be people, places, thoughts, or feelings. A state of emotional numbing, social and/or affective detachment often set in as well. Victims also report sleep disturbances, violent and unpredictable mood swings, exaggerated startle response, an attitude of hypervigilance, and great difficulty staying mentally focused.

While some researchers assert that much of humanity began living in a traumatized state when their societies ceased to be organized around

a nature-based existence (Glenndinning, 1994), the majority of clinicians reserve the posttraumatic descriptor for those dealing with the consequences of exposure to extremely fearful situations that evoke feelings of overwhelming terror and helplessness.

Individuals vary in their reactions to traumatic events due to cultural, social, personality and developmental factors, as well as the specific nature of the stressor. Environmental attributes, such as the human community's belief system, understandings, and how its members are socialized will have an influence on individual trauma responses (Harvey, 1996; Becker, 1995).

According to Goleman (1995), intrusive memory is the essential feature of posttraumatic stress. The traumatic event appears and reappears as uninvited recollection that leaves the victim as if face to face with the terrifying situation, often accompanied by many of the physiological reactions present upon exposure to the distressing event. An instance of excruciating fear has cast its imprint on the victim's emotional wiring, thereby blocking the horrific experience from entering the annals of the memory's normal processing and storage system.

Exposure to terrifying experiences causes alterations in the brain that encompass the limbic system, in particular the amygdala and the locus ceruleus which determines the supply of the catecholamines that are responsible for rallying the body in times of emergency (van der Kolk, Greenberg, Boyd & Krystal, 1985; van der Kolk, 1987; Giller, 1990). It is as if the survivor's internal smoke detector were always sensing fire. Victims live in a perpetual state of emergency and hypervigilance (van der Kolk and Greenberg, 1987; Herman, 1992a; Goleman, 1995). "...(T)he physiological hyperarousal following trauma is due to chronic alterations in the central neurotransmitter systems" (van der Kolk and Greenberg, 1987). The pituitary gland, which houses a stress hormone that regulates emergency fight or flight response, is affected by alterations in the circuitry connecting it to the limbic brain (Giller, 1990). This results in overabundant hormone release, which translates behaviorally into

emotional overreactivity. What's more, the opioid system of the brain becomes overly active, numbing the victim to pain and increasing her or his threshold of tolerance. Trauma survivors tend to oscillate between intense emotional reaction (sometimes on the scale of the original trauma), and emotional numbing and withdrawal (van der Kolk and Greenberg, 1987; Herman, 1992a; Goleman, 1995).

The recognition of psychological trauma has exploded into public awareness and inspired waves of studies that seem to trail the devastating effects of man-made disasters such as war and genocide, rape, domestic violence, and social violence in its various forms. The terminology to describe trauma has evolved, at times, emphasizing the characteristics of the stressor, other times, focusing on the biological impact of the trauma. The shell shock (Southard, 1919) and traumatic neuroses (Oppenheim, 1923) discussed in the literature at the beginning of the twentieth century were precursors to the physio-neurosis of the nineteen forties (Kardiner, 1941). Thereafter, efforts to come to the aid of survivors of WWII's death camps compelled the mental health field to search for and develop new descriptors, treatment studies, and strategies to bring some modicum of relief to such great, unspeakable suffering. Reflecting on his experiences as a concentration camp survivor, Bettelheim (1943) argued that psychological traumatization due to human-made disaster is unique. He used the term "extreme situation" to describe the hopelessness and inescapability suffered by victims terrorized by other human beings.

By the time U.S. soldiers were sent to Vietnam in the nineteen sixties much had been discovered in the psychiatric field about the human response to traumatic exposure. However, as Kolb (1993, p. 296) opined, "it seemed that none of the available psychiatric knowledge about post-trauma was applied." Soldiers were ordered back into combat in spite of having broken down psychologically and were repeatedly exposed to traumatizing experiences with scant provision for their psychological safety. After so many men and women veterans returned to the United States from Vietnam psychologically crushed, a new wave of U.S.-based mental health research and treatment studies began, this time focusing on

biological research (Kolb, 1988; Giller, 1990; van der Kolk, 1987) aimed at better understanding the neurological changes in the brain following an experience of overwhelming fear and emotional stimulation.

This surge of studies in the U.S. coincided roughly with substantial work on the part of Latin American mental health practitioners who found themselves face to face with a clientele characterized by a shared history of recent military harassment, detention, torture, mock executions, disappearance, and forced exile. Their research focused on the social context of the traumatizing experiences, the creation of "bonds of commitment" (Lira & Weinstein, 1984) between therapists and client, and denunciation of human rights violations from the perspective of mental health (Lira Kornfeld, 1995). Building on Bettelheim's (1943) concept of extreme situation, Khan's (1977, as cited in Becker, 1995) discussion of cumulative trauma, and Keilson's (1992) focus on sequential traumatization, some Latin American practitioners developed the term extreme traumatization (Becker, 1995) to describe an individual and collective process in the context of social reality. The contribution here is the shift of emphasis from individual trauma to the traumatic situation, thereby recasting the intrapsychic suffering in the framework of sociopolitical process.

1.2 The Various Human Responses to Trauma

1.2.1 Emotional Response

Based on their considerable research and professional experience with victims, McCann and Pearlman (1991) summarize post-trauma emotional response patterns as fear and anxiety, depression, decreased self-esteem or identity problems, anger, guilt and shame. Diminished responsiveness, feeling constantly threatened (DSM IV, 1994), paranoid suspiciousness, and antisocial acting out (Epstein, 1990) are also common emotional reactions postvictimization. Janoff-Bulman (1992) offers a twofold explanation for the survivor's anxiety: exposure to intense fear leaves personal survival in doubt, while at the same time jeopardizing

and challenging the victim's personal belief system about the nature of the world. She adds that the victim's internal world:

> is in a state of chaos. Victims cannot derive any equilibrium from prior assumptions, for they are no longer adequate guides to the world. The result is cognitive disintegration...This double dose of anxiety, which occurs on top of the initial fear in direct response to the victimization, is the psychological counterpart of physiological arousal (p. 65).

On the one hand, there is the presentation of denial and emotional numbing. On the other, and compounding an already fragile situation, there is terrifying intrusive memory. This seemingly implausible dance of denial and intrusion——of turning away while simultaneously reliving what was most fearful—— can be interpreted as a stunning representation of a victim's ability to self-regulate and self-protect after exposure to terrifying events. Denial facilitates the survivor's processing of the event at her or his own pace, while reliving leads the victim to confront it (Breznitz, 1983). And yet, as Janoff-Bulman (1992) elucidates, all too often this delicate balance has been misunderstood:

> Traditionally, Western psychiatry and clinical psychology have regarded the accurate perception of reality a primary criterion of mental health, and coping strategies have generally been regarded as adaptive if they emphasize or facilitate accurate reality testing...(P)sychologists have tended to regard denial as a sign of underlying psychopathology.
>
> It is probably an understatement to conclude that, psychologically, denial has been underappreciated. From the present perspective on trauma, denial is far from a maladaptive mechanism suggesting psychopathology. Rather, it is a useful and valuable process that reflects the survivor's extraordinary psychological predicament postvictimization (pp. 97-98).

If stress and violence persist in the victim's life, they need to be cautious about expressing their feelings (Richman, 1993). In these cases, denial may be a useful strategy when severe stress is unwavering. Rather than explore and dismantle defenses, counselors and therapists may need to support and bolster them. Nevertheless, when there is an excess of denial,

dissociation occurs resulting in the victim disavowing considerable parts of the traumatic event. Recollection of the original stressor is inaccessible, lodged in a place that while separate from consciousness, is still capable of inflicting emotional and physiological suffering on the victim (Janoff-Bulman, 1992).

1.2.2 Cognitive Response

Cognitive response to traumatic experiences is frequently presented as either the incongruity of having to process new information with old tools, or mental models that up until the traumatic event were adequate for explaining the victim's relationship to the world and vice versa but have since been destabilized (Horowitz, 1986; Janoff-Bulman, 1992). As Horowitz (1986) indicates:

> Until memories of traumatic life events can become integrated with mental schematizations, they are stored in an especially active form of coding. These "memory contents" tend toward repeated mental representation – that is, they tend to be repeatedly examined (p. 246).

The integration of new and horrifying information into the victim's mental schemas is a gradual process. Basic assumptions are slower to change and less likely to be modified than non-essential ones (Janoff-Bulman, 1992).

Victims tend to experience other cognitive shifts as well, such as difficulty in concentrating. Flashbacks and intrusive recollection are the most common, while dissociation, an extreme manifestation of cognitive disturbance, is less so. According to McCann and Pearlman (1991), empirical findings suggest that posttraumatic stress is associated with cognitive deficits, such as impaired verbal fluency, memory, and attention, and an overall decline in intellectual functioning. They recommend more research, particularly with regard to how these deficits effect adolescents postvictimization.

1.2.3 The Behavioral Response

The literature amply reports cases of post-trauma victims exhibiting aggressive behavior, outbursts of anger, self-destructive and impulsive behaviors (DSM-IV, 1994; Figley & Levantman, 1980), high incidence of suicidal behaviors, particularly among returned war veterans (Pallmeyer, Blanchard, & Kolb, 1986; Figley, 1978; Figley & Leventman, 1980; Wilson & Krauss, 1985; Lifton, 1982), substance abuse (van Kampen et al., 1986; Lindy et al., 1988), especially with those who suffered prolonged trauma, and impaired social functioning (Roberts et al., 1982). McCann and Pearlman (1991) cite social withdrawal and isolation, weakened school performance and poor peer relations, poor social adjustment, and diminished occupational achievement as characteristic of trauma survivors.

1.2.4 Physiological Response

Physiological hyperarousal is perhaps the most obvious biological effect of psychological trauma. Exposure to fear-producing situations hurls the body into a state of alert, producing increased autonomic nervous system response and alterations in the brain's circuitry. Exposure to extreme trauma conditions the brain to put out a call for increased catecholamines that regulate the body's internal alarm system (van der Kolk and Greenberg, 1987; van der Kolk, Krystal, et al. 1985). A shortage occurs when these neurochemicals are consumed faster than they can be replenished:

> This depletion is believed to produce changes in the sensitivity of neurons, such that they become overly sensitive to later stimulation...The trauma victim is thus left in a state of hypersensitivity and decreased tolerance for subsequent arousal. Even minor stress and stimulation can trigger major autonomic arousal (Janoff-Bulman, 1992, p. 67).

Victims experience heightened startle response, sleep disturbance, and physiologic reactivity upon exposure to events that remind them of the traumatic stressor (DSM-IV, 1994). Those who have suffered repeated

physical abuse may have damaged central nervous systems, known to cause neurobehavioral dysfunctions (McCann and Pearlman, 1991).

1.2.5 Social Response

Trauma survivors are deeply affected in their social relations as a result of their exposure to stressors. Concurrently, social relations, community values, beliefs and traditions can support victims after exposure to violence (Harvey, 1996). Community response to violent and traumatic events will influence each individual's reaction because of the interplay of the person-community "ecosystem" (Harvey, 1996). The characteristics of the stressor tend to be directly related to social response, e.g., victims of sexual assault report a high incidence of sexual problems and difficulties with intimate relationship. The rebuilding of trust in interpersonal relationships is often an issue for trauma survivors (Herman, 1992a).

1.3 Theoretical Perspectives on Trauma: An Overview

A voluminous amount of literature has been written on psychological trauma by practitioners and researchers guided by a wide variety of perspectives. This reveals distinct views about the formation and symptomatology of posttraumatic response, as well as assessment and treatment. The different theoretical orientations and professional experiences, as well as the sociopolitical and cultural context of the practitioner influence the convergence of ideas and theories (Bracken, 1993).

Some theorists point to the significant distinction between adult and childhood experiences of trauma, emphasizing disparate emotional development (Krystal, 1978). Whereas, children exposed to traumatic stressors tend to become overwhelmed, helpless, and somatize their emotions, their adult counterparts display desomatized emotions, in part because they have the ability to express emotion through language. Adults

have the distinct advantage of self-defense by activating an emotional blocking mechanism before emotions become so strong that they dehabilitate the victim. Krystal (1978) suggests a surrender pattern in adults, consisting of a behavioral paralysis, emotional blocking, and progressive cognitive constriction.

Several theories examine the role of cognition in the dynamics of psychological trauma. How individuals analyze and create meaning of their experiences impacts both onset and recovery from post-trauma. Constructivists argue that:

> psychological reality is constructed. Since it is constructed, if something happens (i.e., trauma) that destroys some of the "girders" of the construction, then repair work must take place. The more devastating the destruction, the more involved the repair work, up to and including the building of an entirely new structure. Out of this view comes the recent recognition that many of the symptoms of PTSD are reflections of the adaptive processes involved in assimilating the new data (i.e., the trauma) (Peterson, Prout, & Schwarz, 1991, p. 6).

Cognitive theorists assume that trauma causes a shattering of assumptions (Epstein, 1985; Janoff-Bulman, 1992; Rojas, 1990). When people are exposed to trauma the result is that their fundamental beliefs about the nature of the world and their place in it is dismantled. Recovery implies the development of a new theory of reality capable of containing the traumatic experience.

Cognitive processing models are especially applicable to context-bound and culturally-defined perspectives of trauma. By focusing on the interdependency of cultural and social factors, and individual behavior and experiences, cognitive processing models provide a framework for understanding the impact of culturally-based meaning-making processes (Creamer, 1995).

The information-processing model and cognitive theories of emotion examine the impact of trauma on an individual's mental schemas and the processing of information (Horowitz, 1974, 1976, 1986).

This theory explains intrusive thoughts and images as a function of how memory storage is effected by cognitive processing. If an experience fails to become processed because it was too horrifying, emotional numbing will occur and the recollection of the experience remains in active memory and repeats itself, resulting in intrusive memory.

Psychobiologic models attribute psychological trauma and the characteristic high levels of physiological arousal to physiological changes in the brain's neurotransmitter receptors. These receptors become hypersensitive to trauma-related stimuli (van der Kolk, 1988; van der Kolk et al., 1984; van der Kolk et al., 1985). The alterations in the brain's chemistry explain posttraumatic symptoms such as flashbacks, intrusive memory and thought, dissociative episodes.

Behavioral theorists understand anxiety and fear as the human learned response to the traumatic stressor. Trauma survivors associate particular cues (e.g., sounds, times, places, people, nightfall) with their terrifying experiences. If a cue consistently evokes fear, the cue alone will become fear-inducing. Recovery comes with learning to avoid the triggers which elicit the conditioned fear response. Behavioral theory emphasizes the role of the environment (e.g., trauma-inducing stressor) in the development of symptoms (Keane, Zimering, & Caddell, 1985).

Several additional theoretical frameworks also compete for the interest and allegiance of clinicians and survivors. The psychosocial framework of Green, Wilson & Lindy (1985), behavioral/learning theory model of Keane et al. (1985), constructivist self-development theory of McCann & Pearlman (1991), psychodynamic formulation, psychoformative perspective, ecological view (Harvey, 1996), and nontraditional, culturally appropriate formulations emanating from non-Western settings (Lykes et al., 1993) all attempt to describe the phenomena of psychological trauma. This myriad of conceptual approaches are mentioned as an indication of the scope and diversity of existing contributions that reflect different types of understanding and interpretation to the study of trauma.

While early trauma research attempted to explain a victim's trauma response by pointing to prior psychopathology (Frank et al., 1981; Foy et al. 1987; Frasier, 1990), according to McCann & Pearlman (1991), Janoff-Bulman (1992), and Vidal (1990a), the nature of the traumatic stressor holds the key to understanding the victim's response to trauma. This idea is supported by the prevailing view that posttraumatic stress disorder can develop in people without any such preexisting condition (DSM-III-R, 1987). In fact, the growing number of journal articles and books on the role of secondary trauma in therapists suggest that no person is immune to trauma (see Stamm, 1996; Munroe et al., 1995 in C. R. Figley (Ed.); McCann and Pearlman, 1990).

The identification of growing numbers of post-trauma survivors following the war in Vietnam had a profound impact on the psychiatric and behavioral fields. For the first time, in 1980 the American Psychiatric Association included in its Diagnostic and Statistical Manual of Mental Disorders (3rd. edition) (DSM) the diagnostic category of posttraumatic stress disorder. Long awaited and greeted with some sighs of relief, many researchers and practitioners also found fault with its formulation. Even now, after the appearance of DSM's fourth incarnation (1994), the discussion continues.

1.4 The PTSD Model

The central characteristics of PTSD as first described in DSM-III are the existence of a recognizable stressor that evokes distress in almost anyone, a reexperiencing of the trauma through intrusive memories, dreams or flashbacks, numbing or reduced involvement with the outside world, feelings of detachment, and constricted affect. At least two of the following symptoms appear in response to the trauma: exaggerated startle response, sleep disturbance, survivor's guilt, difficulty concentrating, avoidance of activities that are reminders of the trauma, and an increase of symptomology when exposed to analogous events of the traumatic episode.

In the DSM-III-Revised (1987) the category of PTSD was expanded to include a greater emphasis on the avoidance of thoughts, feelings, activities and/or situations associated with trauma, along with an inability to recall aspects of the trauma. Between 1980 and 1987, a growing body of evidence emerged indicating that avoidance of painful memories was a key feature of PTSD. DSM-III-R also included a description of the syndrome in children and the specific symptoms they may exhibit upon exposure to traumatic experiences. There is mention of the role of dreams, nightmares, and repetitive play as avenues used by children to relive the trauma. In addition, the revised edition suppresses "survivor guilt" from the diagnostic criteria list.

An essential feature of the PTSD diagnosis is identification of the nature of the traumatic stressor. The traumatic event responsible for the PTSD may be derived from war, organized violence, assault, rape, natural disaster, or accidents. The event entails a threat to one's life or physical integrity, that of one's significant others, the unexpected destruction of home or community, the witnessing of another person's death or injury, physical violence, or learning that one's family is endangered or harmed.

In DSM III and III-R, PTSD is defined as the development of symptoms following exposure to an event that would be psychologically distressing to almost anyone and outside the range of usual human experience. In DSM IV the authors deleted "range of usual human experience," perhaps agreeing with one of the criticisms of the original formulation of PTSD (Herman, 1992a; O'Donohue & Elliott, 1992): namely, that "usual human experience" assumes a homogeneity of experience that is refuted by the disparate realities of women and men, poor and rich, those who survive in war-torn lands and those who live in relatively stable societies. What's "usual" for some may not be for others.

Janoff-Bulman (1992, p. 50) points out that "...the PTSD classification serves as an aid to diagnosis rather than as a description of the victim's psychological experience." McCann & Pearlman (1990, as cited in Janoff-Bulman, p. 50) add that PTSD is simply a "slice of the pie," which is "not

meant to incorporate the complex psychological phenomena associated with trauma but rather represents the most parsimonious view of post-trauma sequelae that differentiates it from other disorders." Becker (1995) adds that PTSD was probably never intended to be a concept or interpreted as a theory.

In spite of the considerable discussion about PTSD, some fundamental questions still remain with regard to its utility within the DSM model: What are the cultural assumptions behind the concept of PTSD? What, if any, relevance does the PTSD formulation have to communities in the non-Western world? Can the concept of PTSD be helpful in describing realities as divergent as those of an invading army that strikes and retreats, and rural peasants experiencing protracted horror at the hands of dehumanized army battalions? Can the same diagnostic category describe the reality of those who suffer for having committed atrocities, while encapsulating the experience of those who were helpless and violated by those very atrocities? Is there a differential impact on the invader and the invaded, considering that the diagnostic assessment of the psychological well-being of all people was developed largely to assist invaders in overcoming their own psychological devastation? Becker (1995), a Chilean practitioner and researcher, argues that for his clients, the *P* of PTSD is misleading and incorrect because the traumatic stressors they were exposed to were not circumscribed to a specific moment in time. When people's lives have been constantly riddled with horrifying and grief-inducing events, how can the beginning of traumatization be established? Likewise, when victims experience successive traumatic experiences, symptomology can persist for decades.

Given the increased interest in the psychological effects of war and organized violence by mental health practitioners (Bracken et al., 1995), there is a pressing need for greater understanding of the varied impact of war on human society. This would hopefully create relevant strategies for treatment and rehabilitation. By examining the literature that questions the applicability of posttraumatic stress disorder diagnostic criteria to

realities other than the United States', we hope to come closer to some of these answers.

1.5 The Role of Culture in the Understanding and Treatment of Psychological Trauma

In the context of the larger debate with regard to meaning and methodology in psychological cross-cultural research (Bracken, 1993; Kleinman, 1987; Marsella, 1982; Murphy, 1986; Berrios, 1988), many researchers and practitioners engaged in cross-cultural studies raise numerous questions about the applicability of the concept of PTSD. At the center of their query is the existence or absence of trans-historical and cross-cultural standards for interpreting psychiatric disorders.

The 'old' cross-cultural psychiatry, with its positivist and empiricist approach represents itself as objective and value-free (Bracken, 1993). Therefore, formulations on research, assessment, and treatment based upon this approach are displayed as neutral. In this way, psychiatry, while birthed in the West, is delegated by its founders and followers as possessing a status of privileged metatheory and methodology. According to Bracken (1993), a post-empiricist philosophy of science is more applicable to cross-cultural psychiatry. He argues that:

> The dominant philosophy underlying recent psychiatric research has been empiricist and positivist and has endorsed a naturalist ontology and epistemology. DSM III was hailed as a major advance because it laid the grounding for more strictly empirical research. Many within psychiatry have dismissed any approach which is not based on the 'scientific method' ... (p. 268).

The purported 'theory-free' (Lock, 1987) attributes of the American Psychiatric Association's DSM are questionable due to the value-laden nature of their formulation and application. In the pretension of universality is the underlying belief that the individual is the critical point of reference in the human experience, rather than the collective. This is quite understandable given the Western social bias toward individuality; however, the problem lies in projecting this cultural assumption onto all

the world's peoples. The ability to detect similar symptoms in dissimilar cultural contexts does not indicate that these symptoms hold the same meaning in all settings (Bracken et al., 1995). The notion that a phenomena identified in one place can be found everywhere (empiricist epistemology) purports these symptoms exist prior to and independent of psychiatric theory. Only then can the idea of universally similar categories of mental disorder be put forth.

A plethora of devices has been developed to facilitate the assessment and diagnosis of trauma – standardized questionnaires, symptom inventories, interview protocols [1]. Several authors raise concerns about assessment and intervention tools that fail to take into account a trans-cultural perspective, pointing out that methodological problems arise from attempts to measure PTSD with questionnaires developed outside of the victim's culture. This results in inadequate assessment (Richman, 1993):

> The difficulties of transposing concepts and words from one society and one language to another, have received insufficient attention, so that culturally determined expressions of distress and concepts about suffering are largely disregarded (p. 1291).

A question is how much of this cross-cultural problem exists due to the assessment tools per se compared to <u>how</u> they are used, <u>who</u> uses them – particularly the rank and power differential between user and survivor. Equally important is the <u>context</u> of their use, and if those being assessed have been given proper information to adequately decide whether to participate in an assessment process. The use of questionnaires may not be a problem defined by the PTSD diagnostic category, but of how the tools are formulated, applied and the lack of careful attention to the context of their application. In addition, because all human experience is relative, assessment tools may overlook the importance of how victims both cope

---

1 see Harvard Trauma Questionnaire; Hopkins Symptoms Checklist-25; Childhood War Trauma Questionnaire; SCL-90-R; Structured Clinical Interview for DSM III-R; Jackson Interview for Combat-Related PTSD; Impact of Event Scale; Diagnostic Interview Scale.

with and prioritize their personal traumas. As Summerfield (1995) points out:

> We need to know more about traditional coping patterns in a particular society and whether these have been disrupted by conflicts destroying not only peoples but also ways of life. Where these patterns still exist, helping agencies can seek to facilitate or at least not retard their function (p. 23).

Qualitative methods of inquiry and observation might prove most helpful to practitioners and researchers interested in learning more about local coping strategies.

1.6 The Latin American Psychosocial Approach: the Role of the Healer

It is no wonder that since the nineteen eighties Latin America has been the birthplace of considerable psychosocial research and practice. It was during the nineteen seventies that state terrorism had its hold on several countries throughout the continent. The militarization of civil society and subordination of socioeconomic policies to the alliance of big business and the armed forces created widespread repression and terror for significant sectors of the population.

The psychosocial focus in the Latin American psychotherapeutic literature has been most prevalent since the mid-nineteen eighties. The tendency in the literature is to move away from the application of a medical model (CEDDI, 1992). While influenced by the psychoanalytic model, systems theory, existential humanism and cognitive behavioral theories, Latin American psychotherapists also rely on dialectical and historical materialism to examine the impact of macro-social issues on individual and collective mental health. Much of the research reflects a concern for ethical issues in therapy and the role of social activism in recovery (Lira Kornfeld, 1995).

According to assassinated psychologist and Jesuit priest Ignacio Martín-Baró (1994), the appropriate role of the psychologist or mental

health counselor is to support people in understanding their own realities through examination of and reflection on their social experience. The prevailing individualism in Western psychology assumes individual responsibility for that which is oftentimes a product of social relations. Barudy (1990) points out that psychic suffering and mental illness are a product of interactions that are incompatible with life. The role of therapy is to create a context for interactions that are life-affirming. The problems of mental health cannot be solved by medicine or psychotherapy alone. On the contrary, the role of the judicial system, culture, society in general, and its moral code play an overwhelming role in the recovery of survivors. Victims benefit from joining efforts to help others who run the risk of suffering a similar fate (Rojas, 1990).

Political repression is the manifestation of the psychopathology of social conflicts. Rather than viewing repression as an aberration or the morbosity of a few irrational individuals, it is deemed an extension of repressive social policies. In much of the Latin American literature, the issue of psychopathology is used to focus on perpetrators rather than on victims (Vidal, 1990a).

The Latin American psychotherapeutic writings contain a voice of critical self-appraisal for the mistaken application of scientific labels that have stigmatized people who suffer from the impact of political repression (Liwski, 1990). Becker (1995) points out that victimizers use:

> the supposed "disorder" of the victims to justify their acts of cruelty and destruction...If our clinical language voluntarily or accidentally mirrors this self-justifying attitude of victimizers, we evidently run high risks of converting ourselves into traumatizing agents. The victims underwent an experience in which a sociopolitical act of power...was converted into an individual experience. If we call that experience a "disorder," we repeat the denial initiated by the victimizers, and we thereby deepen the trauma (p. 103).

Oftentimes helpers have underestimated the healing power of social activism and been too eager to ascribe diagnostic criteria rather than learning from survivors how they have overcome their staggering losses.

As Latin American psychotherapists and helpers have better identified the source of pathology in society, they have come to embrace participatory research methodologies and popular education, thus bringing forth new areas of reflection and social action (Liwski, 1990).

According to Chilean psychologist Paz Rojas (1990), not everyone who suffers from torture is left with sequelae. For some, this kind of experience sparks a revalorization of life. The symptomology produced by torture is varied and there is no clear post-torture syndrome. Rojas argues that therapists working with victims need to know more than technical skills. They need knowledge of social, political, economic, cultural issues and the principles of human rights, and the doctrines or ideologies that uphold torture as an institution.

Psychology would be more effective by guiding people to distinguish between individual problems and those that are a by-product of societal design and its power structures (Martín-Baró, 1994; Vidal, 1990a). This is particularly significant when applied to situations of institutionalized violence where the status quo portrays a reality that contradicts the experience of vast sectors of the population who, as a result, feel invisible and voiceless. For example, the mass media might applaud the armed forces for their sacrifice in defense of the motherland, while the generalized sentiment of the population is one of terror. In this case, psychology needs to reassure people that they are not delusional (Arditti & Lykes, in Agosin, 1991; Martín-Baró, 1994). When individuals attribute feelings of unease to their inner psychic world, psychology should redirect the attention to the larger social context and its overbearing impact on their lives.

Using Paulo Freire's concept of education for critical consciousness as foundation (1972, 1973), Martín-Baró (1994) argues that the most significant horizon for psychology as a field of knowledge is 'concientization'. While psychology addresses issues of individual alienation, it has not focused its attention on the de-alienation of groups through a critical understanding of the reality that shapes them. Part of Freire's contribution lies in his location

of overriding contextual factors at the center of an understanding of overpowering personal situations. Through a process of dialogical teaching, reflection, and action, individuals theorize about their experiences and see the personal recast in the context of the social framework, and vice versa. The use of Freire's conceptual framework and method in psychotherapeutic intervention helps clients identify the structural underpinnings of their specific personal problems (Korin, 1994). What is truly needed is a careful scrutinizing of the specific mechanisms that lock people into a social identity, causing them to behave as dominated or dominating beings (Martín-Baró, 1994).

Martín-Baró (1994) is explicit about not loosing sight of the personal when calling for a greater understanding of the social and collective. These two ideas are not in opposition, but rather the:

> personal here is the dialectical correlate of the social, and as such, incomprehensible if its constitutive referent is omitted. There is no person without family, no learning without culture, no madness without social order; and therefore neither can there be an I without a We, a knowing without a symbolic system, a disorder that does not have reference to moral and social norms (p. 41).

Martín-Baró's writings represent a powerful voice in Latin America's broadly-defined movement of liberation psychology. His work is also widely studied and quoted by U.S. practitioners such as Lykes (1992) who have considerable community-based experience in war-torn developing countries. It is this blend of voices that is producing some of the more interesting cultural critiques of psychiatric paradigms regarding trauma.

The possible implications of analyzing personal trauma in the context of larger social determinants could have a profound impact on treatment alternatives. A healing and recovery process that takes into account the birthing of a new social identity, beyond the confines of the socially constructed oppressed/oppressor roles has the potential for making a significant contribution to the building of social movements that question the existing social order. By developing awareness and

consciousness about the realities that sanction oppressive roles and how these can create war, a new kind of 'concientizing' psychotherapy can be developed. This would enable the individual to discern and affirm a new personal and social identity, beyond the trappings of domination and inequity, based on trust and mutual support. Herein lies part of the rationale for combined educational and psychotherapeutic interventions. This is explored further in Part 3 of this study.

1.7 Trauma and the Healing Relationship

Psychological trauma is an integral part of a human history riddled with untold war, massacre, enslavement, rape, beating, kidnapping and destruction. Somehow, having witnessed and experienced the unspeakable, the collective human heart has survived.

Throughout the centuries healers and caregivers have discovered numerous pathways to heal the emotional and psychic wounds of those who endured the plundering that taints our history. Unfortunately for us today, most of these pathways have gone undocumented. More recently there has been renewed interest in understanding the human hardships created by war and social violence in order to better aid victims in their recovery. Likewise, there is a growing desire to learn about traditional coping strategies that might explain why so many survivors of traumatic experiences do not become psychological casualties (Summerfield, 1995).

With the explosion of research and writing on psychological trauma, the issue of therapist-client relationship has been approached in various manners (Ochberg, 1988, 1991; Wilson, 1989; Peterson, Prout, & Schwarz, 1991; van der Kolk, 1987; Herman, 1992a). Most of the literature concurs that therapeutic work with trauma survivors has its own specificity.

The nature of recovery from trauma is defined in part by the characteristics and duration of the traumatic stressor and how victims plummet into feelings of powerlessness, terror, and isolation. Healing

implies recuperation from an overwhelming sense of helplessness and fear, and a healthy integration process (Roth & Newman, 1991). Healing is also influenced by environmental contributors, the attributes of the victim's community, and her or his relationship to this community (Harvey, 1996). Therapeutic work with victimized people is shaped by the traumatic stressor and the individual's particular response to it, and the therapist's response to the information conveyed and emotion expressed by the victim during the course of therapy. Success often depends on the therapist's ability to be an unfailing witness, guide, and support while the victim does the essential and primary work of restoring a sense of control over her or his life (Herman, 1992a). Understandably, the issue of safety resides at the core of the therapeutic alliance.

Healing approaches to work with trauma survivors challenge long-held assumptions about therapist neutrality, distance, and the issue of boundaries (Greenspan, 1995; Lindy, 1988; Catherall & Lane, 1992; Roth & Batson, 1993; Ofri, Solomon, & Dasberg, 1995; Stefani & Suárez, 1992; Eth, 1992; Lifton, 1976). Neutrality, a long-time pillar of traditional psychotherapeutic intervention, is counter-indicated for work with trauma survivors, particularly those victimized by other human beings. Referring to the body of Latin American psychosocial research, Stefani & Suárez (1992) point out that:

> A common denominator in all the research is the focus it gives to the issue of therapeutic neutrality. None of the studies defend neutrality as viable or useful; rather they argue its theoretical and practical impossibility in the terrain of sufferings due to socio-political etiology (p. 6).

With the decimation of trust and devastation of personal belief system that follows exposure to trauma, survivors need to know where helpers stand. Neutrality for the sake of 'scientific objectivity' is a pale offering. Herman (1992a) makes the valuable distinction between technical neutrality–refraining from giving advice or usurping the victim's right to make her or his own decisions–and moral neutrality." Working with victimized people requires a committed moral stance. The therapist is

called upon to bear witness to a crime. She must affirm a position of solidarity with the victim"(p. 135). Likewise the distance model of psychotherapy can have a deleterious impact on trauma survivors. According to the testimony of clients who endured the distance model of psychotherapy, Greenspan (1995) offers that "it was neither safe nor trustworthy; it has been a progressive experience of disempowerment that comes from years of being treated in a system that devalues and pathologizes connection "(p. 56).

Greenspan argues that the distance model is an integral part of the "cult of the Expert," which in turn, is part and parcel to the hierarchical belief that it will be the adeptness, experience, and cleverness of the therapist that will rehabilitate the dysfunctions and right the misfortunes of the patient. She goes on to analyze how therapists who adhere to the distance model tend to distrust their intuition and deem them "boundary lapses":

> Sometimes the client's "manipulations" or "seductiveness" are blamed for these outbreaks of authenticity, leading to a kind of emotional abuse that is not likely to be named as such by professional review boards but that has devastating effects on clients nonetheless (p. 56).

The discussion about distance is related to the issue of boundaries. In the different schools of psychotherapy, having 'good, strong' boundaries is presented as an icon of sound therapeutic practice. Good boundaries are so deemed because they create a safety zone between survivor and therapist with the intent of protecting clients from therapist abuse of power. Exhibiting poor boundaries suggests the possibility of physical, emotional, or sexual abuse on the part of the therapist (Greenspan, 1995).

The power differential within the psychotherapeutic construct requires that therapists cultivate self-awareness so as not to abuse their power. Part of the therapist's role is to demystify knowledge and extinguish the use of arguments based on so-called therapeutic expertise (Korin, 1994). Therapists need to acknowledge the inherent inequality of

the therapeutic relationship, and share their socially-condoned power with the client.

The fixing of 'strong, good' boundaries in therapy can imply therapeutic distance in situations where victims desperately need assurance that the therapist stands with them in repudiation of who or whatever terrorized and abused them. Victims need to know that their therapists oppose the violence that wounded them, and that therapists will support them in symbolically or actually denouncing the rapist (Roth & Batson, 1993), torturer, batterer, or military commander who gave the orders. They also need to know if the therapist has had comparable experiences. Greenspan (1995) courageously takes this on:

> I am a great believer in the art of therapist self-disclosure as a way of deconstructing the isolation and shame that people experience in an individualistic and emotion-fearing culture. When strict boundaries are used as the litmus test of professional ethical behavior, this art–and therapist authenticity in general–can appear dangerous (p. 53).

Safe connection rather than rigid boundaries affords greater benefit to clients, particularly those who have been violated by traumatic experiences.

When working with trauma victims who have suffered political repression, imprisonment, and torture, it is critical that therapists guard against the following: their own judgment of the victim and what happened to her or him; asking questions in such a way that might remind the victim of an interrogation; making premature interpretations and offering the victim unrealistic expectations of recovery; and, introducing possible solutions that do not emanate from the victim's own analysis of what is needed and what is possible (Rojas, 1990).

Trauma victims seem to respond well to therapists who are fellow trauma victims (Catherall & Lane, 1992; Solomon et al., 1992; Ofri, Solomon & Dasberg, 1995). The term "warrior therapist" is used by Catherall & Lane (1992) to describe former warriors who are now

therapists. This combination of roles poses challenges for therapists who need to shed the coping strategies learned during his or her combat experience. The advantages of this practice can be summarized as follows: the probability of warrior clients being engaged in treatment is higher if the therapist is also a former warrior; the "warrior" therapist is more likely to understand, not judge, and believe that the client's trauma responses are healthy adaptations to an unhealthy situation. "Warrior" therapists assist survivors in becoming emotionally vulnerable and expressive, while modeling for clients how to reframe their traumatic experience and formulate a perspective that includes that experience without blame. Therapists who have not been exposed to trauma-inducing circumstances are more likely to pay excessive attention to pretrauma personality questions (Catherall & Lane, 1992).

A potential pitfall of "veteran" therapists working with veteran clients is the automatic reduction of the client's difficulties to a trauma-related explanation. "Veteran" therapists also run the risk of projecting onto the client their own particular trauma experience and process of recovery (Catherall & Lane, 1992). The latter prevents the therapist from appreciating the specific characteristics, resources and challenges the client brings to the therapeutic endeavor. "Warrior" therapists might require individual therapy while working with clients who may easily trigger their own trauma memories, as therapists attempt to integrate their own experiences so as to differentiate them from those of the client.

The work of Rhea Almeida, founder and director of the Institute for Family Services in Somerset, New Jersey, focuses on group socio-education for male batterers and their families. Relying on the full integration of non-professional lay people, clients are sponsored and mentored by men and women who have 'graduated' from the program (Sykes Wylie, 1996). By introducing a community of peers into lives characterized by isolation and a discourse that purports "what happens in my home is my business," this approach pushes perpetrators and victims to examine the public patterns of domination and power that have been recast in their personal lives. The healing of those traumatized by

domestic violence and the rehumanization of the perpetrators is done under the same roof, although men and women work in separate groups during part of the program. Clients are exposed to an intensive educational effort through videos, books and articles on violence, sexism, racism, and class discrimination to provide social context for their behavior and reframe the meaning of blame, guilt, and personal accountability. The norms of confidentiality and boundaries are cast aside in order for this socioeducational model of therapy to work and prosper.

When referring to the long-term impact of abuse on victims of chronic trauma, Herman points out that "(t)he dynamics of dominance and submission are reenacted in all subsequent relationships, including therapy" (p. 138). In the case of interpersonal chronic trauma, a meaningful therapeutic relationship is necessary for recovery (Roth & Batson, 1993).

The issues of transference and countertransference in the therapeutic relationship have unique meaning when dealing with trauma victims (Haley, 1974; Danieli, 1988; Ofri, Solomon & Dasberg, 1995). The inherent inequality of the therapeutic relationship makes those seeking healing through the therapy relationship susceptible to therapist misuse of power. By definition, trauma victims hold a history of ongoing pain and terror caused by the violation and domination of their will. Therapists need to guard against any abuse of power when working with trauma survivors and exercise great caution as feelings of transference surface.

Transference reactions are unique in trauma victims because they can mirror the complex dimensions of terror, silencing, aggression, helplessness, and self-blame endured during the trauma. If trauma survivors present in therapy with deep distrust, they also bring overbearing dependency needs on their therapists (Ofri, Solomon, & Drasberg, 1995). Lack of awareness of the victim's projections of this paradoxical combination of suspicion, hostility and dependence can render therapy ineffective and unhelpful.

The constructs of traumatic countertransference (Schwartz, 1984), vicarious trauma (McCann & Pearlman, 1990), and secondary trauma (Munroe et al., 1995; Stamm, 1996) all refer to the impact on the therapist or caregiver following exposure to the victim's traumatic memory. While countertransference generally refers to the therapist's emotional response to whatever their client brings to the therapeutic relationship, there are distinctions with regard to work with trauma survivors. Common countertransference themes with victims are anger, fear, anxiety, bystander guilt, grief, numbing of responsiveness (Danieli, 1988; Dyregrov & Mitchell, 1992; Ofri, Solomon, & Dasberg, 1995).

The literature sustains that no one is immune to secondary trauma; all those in close proximity to trauma victims are apt to experience traumatic symptoms. These symptoms are parallel to those of the survivors, originate in the survivor's experiences, and are transmitted to caregivers from survivors (Munroe, 1993). Secondary trauma can be transmitted both through the victim's testimony and the patterns of relationship which victims establish with caregivers (Munroe et al., 1995). If therapists try to deflect feelings of professional and personal ineptitude that might come from the magnitude of their client's needs and the impossibility of offering pain relief, they run the risk of replicating patterns of traumatic engagement by playing parts in the drama of exploiter/exploited, ally/enemy, aggressor/aggressee, rescuer/rescuee (Munroe et al., 1995). Trauma therapists and caregivers can become emotionally overwhelmed and experience feelings of helplessness, hopelessness, terror, incompetence, grief, and a great sense of vulnerability (Armstrong et al., 1991; Dyregrov & Mitchell, 1992). Similar to direct traumatic exposure, secondary trauma violates trust and challenges the victim's fundamental assumptions about life. Treatment teams can play a key role in prevention by providing therapists with a community that recognizes and intervenes to change trauma engagement patterns (Munroe et al., 1995).

One of the goals of treatment teams is to prevent therapists from developing unhealthy attachments to victims. The therapist as facilitator

to healing has to balance showing empathy and expressing solidarity, with avoiding being a rescuer obsessed with 'saving' the victim.

With so many probable countertransference entrapments, therapists working with victims face a difficult challenge. Wilson (1989) points out that the spectrum of reactions:

> all potentially interfere with the creation of a strong therapeutic alliance which will enable bonding, support, trust, and the necessary safe "holding" environment to work through the problems associated with the denial/avoidance and intrusion phases of posttraumatic reactions (p. 204).

Ironically, in successful therapy when the victim integrates the traumatic experiences, the therapist may attribute this integration to their own special ability or gift:

> These self-images and attributions are a form of narcissistic self-representation born out of the therapist's struggle with the empathic distress emanating from the process of treatment...(S)uch a schema for enactment contains both grandiosity and distortion which can potentially interfere with the progress of therapy when the therapist's desires for admiration and recognition need to be reinforced through the process of psychotherapy.
>
> Thus, in order to sustain narcissistic gratification, the counter-transference reaction may also include a belief that the clinician has a personal obligation to shoulder the responsibility for the stress recovery process (Wilson, 1989; p. 210).

The dangers of transference and countertransference in the therapeutic relationship with trauma victims serve to underline the crucial need for a team effort on the part of caregivers, family and community members. Munroe (1993) suggests guidelines for personal ethical action for caregivers. These guidelines recommend recognition of the real danger posed by secondary trauma and a solid commitment to team work. They encourage therapists to use their feelings and urges as important clinical data, and underline the direct relationship between therapist well-being and client well-being. By reminding therapists that there are no formulas

or preordained solutions in therapy, Munroe's guidelines encourage the creation of professional communities that can recognize and promote their use through therapist self-care. In Chapter Two we will continue to explore approaches to healing and recovery.

CHAPTER 2
ASSESSMENT, TREATMENT, AND RECOVERY

2.1 The Meanings of Recovery

Just as there is no single definition of psychological trauma in the literature, the similar is true with recovery. Though varied in their interpretations of which criteria indicate recovery, many studies seem to agree on the need for a multi-faceted approach to healing that places the individual in a larger social context. Some models emphasize this more than others, as in the case of the ecological view of recovery (Harvey, 1996). Writings from Latin America underline the importance of societal and community healing (Rojas, 1990; Martín-Baró, 1994), and recommend in-depth therapist examination of the traumatic experiences, rather than the symptoms, in order to understand and help victims (Becker, 1995).

Some clinicians equate recovery with the culmination of successful therapy and the victim's overcoming of pre- or post-trauma psychological conflicts. Others define recovery as the abatement of symptoms, particularly arousal and intrusion. With the former, it is difficult to distinguish recovery from the achievement of global mental health (Harvey, 1996). The latter, although useful in informing treatment approaches, fails "to consider, for example, the sense of shame and self-blame that can persist in the face of symptom relief or the equally persistent sense of separateness and mistrust (experienced by survivors)" (p. 11).

Some writings point to the passage from victim to survivor as a hallmark of the recovery process (Herbst, 1992; Janoff-Bulman, 1992; Merwin & Smith-Kurtz, 1987; Aron, 1992). For victims of chronic abuse, recovery entails a dynamic process that fosters integration of the traumatic material into one's personality (Horowitz, 1986), and can best occur in the context of a meaningful therapeutic relationship (Roth & Batson, 1993).

Recovery implies reestablishing cognitive stability and emotional health by rebuilding assumptions which integrate the old world view with the often crushing reality of new and frightening experiences. This integration can imply an assessment of lessons learned through the victimization process, often about self-worth, courage, reappraisal of life's meaning and subsequent reprioritization of what in life holds significance (Janoff-Bulman, 1992). Merwin & Smith-Kurtz (1987) cite Antonovsky's (1987) study of how healthy people manage stress and attain feelings of confidence associating it with coherence and congruence between internal and external environments. Therapeutic efforts to educate victims about the nature of trauma-induced stress help reestablish predictability and integration of painful experiences.

Herbst (1992) argues that recovery implies the restoration of not only emotional health, but also physical, spiritual, and community health while simultaneously delivering the survivor from a state of powerlessness. The clinical experience at the Marjorie Kovler Center for the Treatment of Torture Survivors indicates that recovery from symptoms is more easily treated than the overcoming of disempowerment that is an outcome of psychological traumatization (Herbst, 1992).

A number of authors emphasize the importance of the physical body in the healing process. Merwin & Smith-Kurtz (1987) argue for a wholistic approach to recovery based on self-healing techniques and critique studies that partialize body and mind. They suggest that emphasis be placed on:

> helping people understand and help themselves, on education and self-care rather than dependence on an "expert."...Particularly with victims of violence, such an approach engenders the necessary regaining of control of one's life and one's person, of self-esteem, and of trust in oneself. These psychological changes, as well as the physical and spiritual recovery, are part of the growth from victim status to survivor status (p. 57).

The authors indicate five components integral to the totality of recovery for outpatient victims of violence: nutrition, physical activity, spirituality, humor, and stress management. While their emphasis on nutrition and humor are hardly mentioned in the rest of the literature (Solomon et al., 1992 is an exception), their failure to note the significance of cognitive reframing and knowledge acquisition about the social origins of violence is noteworthy.

Echoing the call for an integrated approach to the recovery process are Gonsalves et al. (1993), who work with victims of torture. They focus on four key areas: restoring physical integrity by healing the body, promoting psychological reorganization by repairing shattered assumptions about self, examining the multiple losses involved in refugee or exile status, and reintegrating the survivor into sociopolitical life. A critical element underlying these interventions is an awareness of and sensitivity to countertransference dynamics. Healing can only occur in the context of a safe therapeutic environment for the uncovering process when survivors rebuild their sense of trust and security (Jareg, 1995a).

Recovery from trauma implies relearning a more normal response to the original traumatizing events. This cognitive relearning has an effect on the cortical region of the brain. Recent findings suggest that alterations in the brains of PTSD survivors are not irreversible (Goleman, 1995).

An ecological view of trauma and recovery removes the discussion from the arena of the individual in the abstract and places the individual in the midst of community. For Harvey (1996):

> The existing literature on psychological trauma is characterized by a relative underemphasis of environmental contributors to individual variations in posttraumatic response and recovery. The clinical literature, in particular, also tends to overlook the phenomenon of individual resiliency, the possibility of recovery in the absence of clinical care and the contribution of social, cultural and environmental influences to these outcomes. In the literature, the term "recovery" is generally poorly defined and criteria indicative of trauma recovery are seldom specified...

> Individual reactions to events are best understood in light of the values, behaviors, skills and understandings that human communities cultivate in their members (p. 4).

An implication of this model is that clinical interventions do not automatically heal. Community-based interventions are effective in the recovery process and the cultivation of healthy emotional skills.

Chilean psychologist Paz Rojas (1990) posits that not everyone recovers from psychological trauma in the context of a therapeutic relationship. The development of a relationship with a psychotherapist is only one road to healing (Herman, 1992a), and it can either facilitate or obstruct the process of recovery. Victims who have recovered without clinical intervention need to be studied and learned from, particularly to benefit strategies of prevention (Harvey, 1996).

The ecological model assumes that individuals are not equally vulnerable to nor similarly affected by potentially traumatic events. This approach is a far cry from arguments that point to preexisting pathology as the explanation for why some individuals suffer from posttraumatic stress while others don't. The assumption around ecological modeling is that vulnerability to victimization, type of response and recovery are determined by the victim's reaction to the event experienced, and their relationship to the larger environment. Together these factors define the person-community "ecosystem" (Harvey, 1996). Successful or failed recovery reflect the strengths or deficits of the larger system, and the quality and dynamic of the individual-community relationship. Recovery is understood as a multidimensional phenomenon comprised of the following outcome criteria:

1) Authority over the remembering process;
2) Integration of memory and affect;
3) Affect tolerance;
4) Symptom mastery;
5) Self-esteem and self-cohesion;
6) Safe attachment;

7) Meaning-making.

Harvey (1996) recommends these characteristics to clinicians, survivors and researchers as points of reference for individual recovery assessment and for the shaping of clinical and community interventions.

In a similar light, Herman (1992a) argues that because "trauma affects every aspect of human functioning, from the biological to the social, treatment must be comprehensive. Because recovery occurs in stages, treatment must be appropriate at each stage" (p. 156). While distinct, these stages are not linear, tending to spill into one another as the healing process unfolds. According to Herman the three primary stages of recovery are:

1) Attaining a sense of safety;
2) Remembering the details of the trauma and mourning the loss;
3) Reconnecting with ordinary life.

Although there is not consensus that recovery is a three-stage process, we will assume this description as a useful tool for the following discussion.

The essential experience of trauma survivors is one of disempowerment and disconnection from others (Herman, 1992a; Herbst, 1992). Therefore recovery implies empowerment of the survivor and the creation of new connections within the context of relationships. The latter makes it possible for the survivor to recreate the psychological faculties that were damaged, namely, the capacity for trust, autonomy, initiative, competence, identity, and intimacy:

> The best way the therapist can fulfill her responsibility to the patient is by faithfully bearing witness to her story, not by infantilizing her or granting her special favors. Though the survivor is not responsible for the injury that was done to her, she is responsible for her recovery. Paradoxically, acceptance of this apparent injustice is the beginning of empowerment. The only way that the survivor can take full control of her recovery is to take responsibility for it.

> The only way she can discover her undestroyed strengths is to use them to their fullest (Herman, 1992a, p. 192).

Since knowledge is power, if the therapist believes someone is suffering from a traumatic syndrome, this information needs to be shared with the victim as a first step toward their reempowerment. Such knowledge can facilitate relief because having a language for her experience begins the process of mastery.

Practically all of the literature emphasizes the need for the creation of safety for recovery work (Rojas, 1990; Herman, 1992a; Bass & Davis, 1988; Esterio, San Román & Almarza, 1990; Morera & Taboada, 1985; Jareg, 1995a; Gonsalves et al., 1993). Achieving safety requires regaining a sense of power and control on all levels: survivors feel unsafe in their bodies, unsafe with their emotions, memories, thinking, in relation to others. Self-care and self-protection are components of the reestablishment of basic safety, as is the overcoming of posttraumatic isolation through a reintroduction of social support. Herman (1992a) points out that while:

> the single most common therapeutic error (with trauma survivors) is avoidance of the traumatic material, probably the second most common error is premature or precipitate engagement in exploratory work, without sufficient attention to the tasks of establishing safety and securing a therapeutic alliance (p. 172).

Herman also comments that it is not uncommon for survivors to carry the fantasy of a 'quick fix' as the reward for cathartically 'telling it all' (p. 181). A therapist's role includes helping survivors understand that recovery is a process of integration not amputation.

Ideally, once safety has been built, victims can more ably commence the stage of remembrance and mourning:

> The second stage of recovery has a timeless quality that is frightening. The reconstruction of the trauma requires immersion in a past experience of frozen time; the descent into mourning feels like a surrender to tears that are endless (Herman, 1992a, p. 195).

The choice to confront the horrors of the past rests with the survivor. Herman defines the therapist's role as one of witness and ally. Because reconstruction of the trauma places great demands on the courage of both patient and therapist, decisions with respect to pacing and timing need meticulous attention and frequent review. Therapists need to watch for and avert the danger of excruciating intensification of symptomology.

Practitioners use different terms to describe the telling of the survivor's story. Herman refers to the reconstruction of the story (1992a), whereas Agger (1994) and Aron (1992) make mention of personal testimony. Herbst (1992) and Smith (1980) identify oral history as a primary methodology of work with refugee survivors of torture and political repression and Vietnam veterans respectively. These authors concur that by telling their personal story survivors can connect memory to affect, and subsequently use those feelings as a pathway toward a reassessment of the meaning of the traumatic event. Herman (1992a) attests that the actual telling of one's personal story can alter the abnormal memory process that is so typical with post-trauma victims. "The *physioneurosis* induced by terror can apparently be reversed through the use of words" (p. 183).

Herbst (1992), in her work with Khmer and Guatemalan women refugees in the United States, suggests that oral history is a primary tool for the empowerment and recovery of trauma survivors. Oral history can foster the formation of groups as survivors come together to share and listen. As members begin to trust the group process, they are also willing to express and release anger. Initially directed at the perpetrators of the institutionalized violence that befell them, their anger eventually extends to abusive husbands and disobedient teenage children. These resultant feelings of empowerment transfer to behavioral changes, most notably in the expression of an interest on the part of Khmer women to return to their country to help others (Herbst, 1992).

In her analysis of the therapeutic treatment of people who have suffered trauma under state terrorism, Aron (1992) underscores the social and political ramifications of testimony. As sociotherapy, testimony has

something to offer both the individual and the community. But does the rendering of testimony accomplish more than the education of the listener? Does it heal the teller, and more importantly, does it help to transform victim into survivor? Aron comments that:

> (w)hen the refugee stands before an audience made up of people who have no personal stake in repudiating the things that have happened, apart from their outrage as decent human beings, this is a powerful indication that not just *I*, but *We*, understand that such things must not be allowed to happen (p.187).

Those opposed to testimony as a healing technique argue that there:

> are those who feel that the duty to bear witness in this way constitutes yet another imposition on the refugee, forcing the victim to comply with somebody else's agenda, somebody else's idea of what needs to be done (p. 186).

Bracken (1995) is concerned that when a PTSD diagnosis prompts testimonial sharing, the careful rendering of testimony is given priority over the development of a contextual response to violence.

The initial step of the third recovery stage of reconnection is reconciliation with self. Compassion and respect for the traumatized victim-self join in celebration of the survivor-self (Herman, 1992a), thereby marking the first instance of reconnection.

> As survivors recognize their own socialized assumptions that rendered them vulnerable to exploitation in the past, they may also identify sources of continued social pressure that keep them confined in a victim role in the present (p. 200).

This identification can lead to social action which draws on the survivor's inner strength——the very inner strength that has been crushed by victimization. Often a group endeavor, social action opens a possibility of shared intention and activity with others who suffered a similar history and now face a similar challenge.

2.2 Approaches to Assessment

The varying therapeutic approaches to assessment are a reflection of the variety of interpretations of the recovery process. Most of the literature on assessment recommends combining several diagnostic tools, dependent on the specific characteristics and needs of the survivor (Litz et al., 1991). As mentioned earlier (see chapter 1), many devices (questionnaires, inventories, etc.) have been created to facilitate the assessment process. Critics of these devices point out that their focus on symptomatology makes their usefulness questionable, particularly when victims have been exposed to successive traumatizing situations. This is because most assessment tools fail to examine how victims prioritize and understand their experiences (Summerfield, 1995).

Some believe that assessment is easier with those who have suffered a recent acute trauma (Herman, 1992a). With victims of prolonged, repeated trauma, diagnosis is not so straightforward. Disguised presentations are common. In cases of severe dissociative disorder, diagnosis can take years.

According to the ecological perspective, an effective clinical intervention with trauma patients begins with assessment that is informed by a multidimensional definition of trauma recovery which emphasizes the importance of identifying domains of strength as well as domains of impairment (Harvey, 1996; p. 20).

In listing the assessment tools used in a study with Guatemalan refugee children exposed to war-induced psychological trauma, Melville & Lykes (1992) mention both structured and open-ended interviews and taped personal story with children, as well as psychological instruments such as the house/tree/person, kinetic family drawing tests, and an instrument called 'photo themes'. For a different kind of information-gathering they relied on qualitative interviewing and observation tools by visiting the children in their homes and at school, and meeting with teachers and surviving parents. Application of these tools allowed

researchers to gain insight into the overall well-being of children suffering the long-term effects of systematic violence.

Litz et al. (1991) suggest that psychological assessment of trauma victims:

> includes not only a delineation of symptoms, but also an evaluation of the nature of people's traumatic experience, their unique mode of adaptation, and their methods of coping with the often-debilitating symptoms of posttraumatic stress disorder (PTSD)(p. 50).

The assessment process can be a valuable time in the recovery of the patient. Litz et al. (1991) recommend three methods of obtaining assessment data: the structured clinical interview, psychometric inventories, and psychophysiological measurement. The goal of assessment of PTSD is to gather data regarding a differential diagnosis and classification of PTSD and other DSM disorders; and an analysis of the person's interpersonal behavior and intrapersonal experiences. Based on this information, a treatment plan can be designed and appropriate strategies selected (Litz et al., 1991).

Some of the literature provides readers with empirically validated assessment instruments and strategies. However:

> While considerable progress has been made in the psychological assessment of PTSD, there is currently no gold standard for diagnosing the disorder. Rather, a multimethod approach, incorporating information obtained from a variety of sources, has been advocated to establish a PTSD diagnosis. The cornerstone of such an approach is the clinical interview...
>
> (N)o single best clinical interview instrument recommends itself in the diagnosis of PTSD. However, there are several structured clinical interviews...Clearly, the population with which one is working will have some bearing on the choice of an instrument (Litz et al., 1991, pp. 51, 54).

If clinician and victim are from different ethnic, racial, cultural or social backgrounds, this can impact on the victim's trust of the therapeutic

relationship. Harvey (1996) explains treatment failures as therapist insensitivity to or misconceptions about the cultural beliefs and resources of the victim, thereby leading to unwise recommendations or choices on the part of the therapist. Gonsalves et al. (1993) address the difficulty of cultural, lingual and social differences between therapist and torture survivor, which can limit the survivor's disclosure. Therapists "must be well informed about the survivors' historical, social and cultural background. Therapists also must learn about the very political culture leading to the events which resulted in the torture assault" (p. 360).

Clearly there is the need for specialized training and preparation of mental health professionals who work with trauma victims from cultural realities other than their own (Westermeyer, 1989). This may also justify the use of community-based para-professionals to assist victims. Because they come from a similar background and might have been exposed to and healed themselves from similar stressors, they are perhaps best able to assist survivors without cross-cultural misinterpretations.

Much of the literature insists on the use of a structured interview, although it is pointed out that this is not a substitute for careful inquiry into the victim's psychological conflicts, be they pre- or posttrauma. One of the clinician's goals during the interview is to uncover the link between traumatic experience and traumatic symptoms. The literature recommends that clinicians look for associated problems that reflect either pretrauma difficulties or posttrauma behavior or complications. Like Harvey (1996), Litz et al., (1991) emphasize the need for clinicians to identify the victim's strengths. It is also important that they notice the victim's cognitive response to trauma, particularly in the form of exaggeration of the probability of threat of danger (Solomon et al., 1992).

Assessment of the needs of significant others is also important, both during diagnosis and treatment (Solomon et al., 1992; Litz et al., 1991). Family members are witness to the victim's trauma responses and can play a key role in recovery.

The many psychometric assessment tools have their strengths and weaknesses. Some are based on studies with men in combat-related situations and are therefore not applicable to larger civilian populations; others have not been tested cross-culturally. Not all are applicable to community-based work, outside the bounds of a clinical environment.

2.3 Treatment Models and Interventions

2.3.1 General Considerations

Some practitioners advocate use of multiple techniques and strategies that address specific kinds of symptomology (Litz et al., 1991; Herman, 1992a). For example, intrusion can be treated by exposing traumatically conditioned cues to imagery, whereas avoidance can be reduced by gradually encouraging victims to increase their general range of interpersonal contacts. The symptoms of hyperarousal are primarily addressed through acquisition of stress management skills (Litz et al., 1991). Usually there is:

> some preponderance of either *positive symptoms* (reexperiencing coupled with psychophysiological hyperreactivity symptom clusters) or *negative symptoms* (avoidance behaviors, numbness, withdrawal) that can guide the choice of initial treatment strategies (p. 75).

Herman (1992a) sustains that pharmacological therapy can reduce reactivity and hyperarousal, while behavioral techniques such as relaxation and hard exercise can help in stress management. Cognitive and behavioral strategies can help reduce the confusion of the disorder through the recognition and naming of symptoms. Interpersonal strategies are recommended to reestablish attachments, and social strategies are helpful in overcoming the social alienation that is part and parcel of post-victimization.

Flooding is a behavioral therapy designed to overcome specific fear-based responses by exposing victims to a controlled reliving experience. Victims are taught how to manage the anxiety they feel upon exposure:

> Therapeutic techniques for transforming the trauma story have developed independently for many different populations of traumatized people. Two highly evolved techniques are the use of "direct exposure" or "flooding" in the treatment of combat veterans and the use of formalized "testimony" in the treatment of survivors of torture (p. 181).

In the testimony method as first reported by two Chilean psychologists (Cienfuegos & Monelli, 1983), therapy sessions are recorded, a verbatim manuscript is prepared and then revised by victim and therapist. In this work the sociopolitical components of testimony as denunciation are made explicit.

In spite of the usefulness of these techniques, Herman (1992a) is quick to point out that both flooding and testimony fail to successfully address the symptoms of numbing and social withdrawal, namely the relational, social and work problems associated with them. The relational side of traumatic exposure must be dealt with.

Addressing the use of different forms of therapeutic treatment for different kinds of victimization, O'Donohue & Elliott state that (1992):

> ...pharmacological therapy is the object of investigation for war veterans...but not for victims of sexual abuse. Similarly, due to differences in developmental level, play therapy has been recommended for child sexual abuse victims but...would not be appropriate for rape or war victims. Conversely, psychodynamic group therapy treatment approaches would not be appropriate for young children with limited verbal abilities (p. 432).

Merwin & Smith-Kurtz (1987) cite the experience of The Dimondale Center which follows a wholistic format, including a stress reduction approach based on four elements: physical fitness (to reintroduce victims to their bodies), education (relaxation techniques and biofeedback,

assertiveness training, information on the civil and criminal justice systems, victimization, and the sociopolitical community response), psychotherapy (individual and group modalities, and family therapy), and social integration (reintegration with family and friends, and contacts with self-help and support groups). Merwin & Smith-Kurtz (1987) apply posttraumatic therapy (Ochberg, 1988; 1991) that aims to help victims become survivors, and ultimately reassume control and personal mastery of their resources and their lives. Presupposing no previous psychopathology, posttraumatic therapy recommends the development of a strong working relationship between therapist and victim during the recovery process.

The experience of the Department of Veterans Affairs Outpatient Clinic in Boston provides trauma victims with an interesting blend of educational intervention and psychotherapeutic treatment. Veterans are given a written document to read as they begin a ten week program to help gain knowledge about trauma and how it may effect a person's day to day life. They are informed that the program is educational in nature, and while not an appropriate place for directly addressing personal healing, it aims to help prepare them for treatment. The program begins with an examination of their expectations and a setting of group groundrules. Key themes such as trust, safety and self-care, effects of trauma, change and cure, responsibility and shame, survival tactics and relationships, issues and types of treatment, and getting on with life give content to the educational sessions (Munroe & Bitman, 1994).

A number of specific trauma treatment methods that have appeared during the past decade have been met by a mixture of enthusiasm and skepticism from the psychiatric community. The best known of them, eye movement desensitization and reprocessing (EMDR) aims to reactivate traumatic memory in order to desensitize the fear, anxiety, and beliefs associated with it (Shapiro, 1994; Goldstein, 1994; Forbes, Creamer, & Rycroft, 1994; Greenwald, 1994). For some trauma survivors, EMDR seems to signal an astonishing and sudden remission of trauma-related symptoms. For others, it works best when woven into a long-term,

multifaceted therapeutic program. Some report either no effect or harmful impact because of its ability, if improperly used, to induce dissociative states. EMDR's founder, psychologist Francine Shapiro, cautions against its use by those who have not been carefully trained to assess the psychological stability of the trauma survivor. Critics of EMDR allege that there is no reliable research to substantiate claims to the disappearance of trauma symptoms (Montgomery, 1994a; 1994b).

Traumatic Incident Reduction purports to relieve trauma-related symptoms by guiding victims through a process of reassessing the traumatic incident, gaining new insights about it, and defining a different relationship to it (Valentine, 1995). Thought Field Therapy works with the body's energy system by using body taps on acupressure points to alleviate the survivor's existing emotional imbalance.

It is possible that some of these or other specific techniques could be successfully used by para-professionals in a community-based environment. However, there is a scarcity of research on their effectiveness in clinical settings, and to the best of my knowledge, no studies exist about their utilization by para-professionals. Perhaps in the future, their founders and practitioners will see the importance of making them available to para-professionals and thus design strategies and methodologies for training community mental health workers for their broadened application.

2.3.2 Community-based treatment approaches

The reliance on more traditional approaches to healing such as acupuncture, herbal medicine, religious beliefs, and native healers in conjunction with Western assessment approaches are recommended for the successful treatment of traumatized refugees. The importance of group and/or family therapy is also emphasized, given the social fabric of traditional cultures that value the collective over the individual (Peterson, Prout, & Schwarz, 1991; Arredondo, Orjuela & Moore, 1989; Canino & Canino, 1980).

Appropriate treatment of trauma has much to do with the cultural beliefs propagated about the self, its relation to community, and the meaning of illness (Krippner, 1995). By conceptually elevating the intrapsychic to a place of primacy, the interpersonal, social, cultural, somatic and spiritual are downplayed. This relegates the healing process to the inner world of the individual, her/his emotions, understandings and issues (Martín-Baró, 1994; Lykes, 1993). But in many cultural contexts, factors such as "...community cohesiveness and political solidarity determine to a large extent how the traumas of war are experienced and coped with" (Bracken et al., 1995, p. 1078). This argument is supported by Harvey's (1996) ecological perspective on trauma. She advocates a multidimensional assessment of trauma recovery which informs the design of interventions that positively impact the victim's changing relationship to the larger community.

The focusing of attention on the intrapsychic world of the individual can unintentionally stigmatize a person's suffering by separating them from the community. For many, personal healing and recovery are inextricably bound with that of their community (Herman, 1992a; Bracken et al., 1995).

Social support is often a determinant of how human beings deal with atrocity. In certain cultural contexts social support can dissolve for women if they are raped (Bracken et al., 1995). It has been demonstrated that in situations where women are socially stigmatized and ostracized after rape, the repair of social relations is a critical cornerstone to the healing process. By joining with other women survivors to form a group, women overcome their isolation, not necessarily by even addressing their common experience, but by focusing their attention on life-affirming activities such as community development, as in the case of women-survivors of rape in Uganda (Bracken et al., 1995).

Basic therapeutic actions must follow certain criteria for success (Jareg, 1995b), namely that they: be rooted in the community; develop through reliable relationships with groups, families and sometimes

individuals; have specific aims that all who participate understand and accept; promote personal growth through involvement and the building of trusting relationships; involve children directly whenever possible; set in motion sustainable processes; involve local social and educational authorities. Primary health care providers need to learn about how children of different developmental stages react when psychologically distressed (Macksoud, 1993). Teachers need to become aware of how to support children who have suffered losses. Courses for pre-school teachers on how to identify and aid small children who are traumatized would be extremely helpful, as would the creating of community awareness of how children experience the losses of war through discussion with community leaders. Finally children need activities through play and sports, and to be given meaningful tasks in the rebuilding of their communities. The development of self-confidence and self-esteem are identified as solid defenses against the effects of trauma and distress. Competence building workshops are recommended on themes such as health or first aid, as well as group sessions with children and adolescents to allow them an opportunity to express their needs and feelings (Jareg, 1995b).

A number of group-based community treatment approaches have been reported in the literature (Solomon et al., 1992; CEDDI, 1992; Esterio, San Román & Almarza, 1990; Contreras & Corvalán, 1990; Vidal, 1990b; Sykes Wylie, 1996). Solomon et al. have worked with Israeli combat veterans following exposure to intense fighting. Practitioners invested two years in the design and preparation of a one month residential treatment intervention located on an army base. Follow-up strategies include mutual self-help groups in the veterans' communities. The Koach Project, as it is known, combines behavioral, cognitive, and group approaches in an integrated model. One of the project's premises is that trauma victims need to be removed, at least, temporarily, from their current surroundings in order to build a new environment filled with optimism and the solid belief that participants are capable of healing the psychological sequelae of their war experiences. Describing their approach as at once pressuring, supportive, and optimistic, the staff encouraged

group pressure to forge a new group identity and move beyond the characteristic isolation that trauma survivors suffer.

In Central America a combination of treatment approaches can be found. Psychodynamic work within a psychoanalytic model, social and political psychology, and community-based strategies coexist. The latter use participatory workshops, as well as pamphlets and other graphic tools to reach large numbers of people. Grass roots materials have been developed primarily by ACISAM (Training and Research Association for Mental Health) in El Salvador, and ASECSA (Community Health Services Association) in Guatemala. These organizations have contributed to advances in the conceptualization of the meaning of mental health, which reflects a psychosocial concern for identifying the impact of the macro system's deficits on individual well-being (CEDDI, 1992).

Group-based experiences involving role plays, dramatizations, collages, body expression (Esterio, San Román & Almarza, 1990; Contreras & Corvalán, 1990) are common therapeutic strategies with those exposed to political repression in Latin America. All reports in the literature emphasize the need for trust-building and group integration in order for this to successfully unfold. Vidal (1990b) argues that multidisciplinary teams of professionals possessing a shared language can have a favorable impact on these interventions.

Many practitioners, both in the West and in Latin America, hail the importance of art therapy for creating outlets of expression and new forms of socialization for those most affected by state terrorism:

> It is probable that art originally developed as a means of expression of and relief from, traumatic experience. Art, song, drama, and dance in primitive times were motivated by a need for catharsis and for gaining control over threats to the community or to the individual. The arts abound at times of nightfall, death, birth, war, and natural disaster, for they help to encapsulate terror. If psychological trauma is the *origin* of art, is it any wonder that the creative arts therapies hold so much promise as a reparative force? (Johnson, 1987, p. 13).

Those involved in human rights and mental health work in Argentina (Anonymous, 1989) explain their work as challenging to both creativity and daily political commitment. They use games, dramatization, art therapy, body work for emotional release, expression, group-building to break isolation and the collective forging of a different kind of social interaction. Morera & Taboada (1985) point out that group-based therapeutic interventions are resisted by those living under repressive regimes because basic trust is undermined and so difficult to establish or sustain.

2.3.3 Treatment approaches for children

Lykes et al. (1993) have made significant contributions to the design of a training of trainers program for adult caretakers of refugee children traumatized by war in Latin America. The program brings together mental health professionals, actors, and primary school teachers, who through a combination of play therapy and story-telling, make it possible for children to give expression to and decipher the meaning of the terrifying events constituting their traumatic experience. By combining drawing, collage, dramatization and storytelling to create an outlet for children's self expression, a process of emotional release rooted in the traumatic experience is facilitated (Lykes, 1993). Work within a group setting encourages the child to reconnect and establish an intermediary space of renewed safety and trust. In a study conducted in Guatemala, Melville & Lykes (1992) set out:

> to analyze the survival resources of children who have witnessed the violent loss of family members and/or sudden displacement from their familial homes and communities, to assess the continued maintenance of their Mayan ethnic identity, and to record their expectations of the effects of continuing and future violence (p. 533).

The intention of the research is to inform the development of community-based care and curriculum materials that support the efforts

of those working with child-survivors. The work of Melville & Lykes represents an interesting blend of popular education, socio-drama, and expressive therapy. Lykes (1994) argues that the group experience in the workshops she facilitates is critical to their success. Very much in the tradition of participatory non-formal education (Freire, 1972, 1973, 1990; Timmel & Hope, 1986; Srinivasen, 1990), the participants introduce the themes that serve as a backdrop for applying the different techniques and modalities of expression. Issues and fears that are voiced in the group constitute the point of departure for a skills acquisition process. Lykes (1994) describes the training as:

> the presentation of a technique; an experiential exercise using the technique; reflections in small groups focused on both one's personal experiences enacting the technique (that is, what did I feel), and the applicability of the technique (that is, how can I use this in my work with children in my community); exchange of experiences in the larger group; and finally, presentation of existing theory and the exploration of alternative conceptualizations emergent from the integration of indigenous traditions and Western psychological practice (p. 549).

This model is designed according to the assumption that children suffer from trauma due to psychosocial factors rather than intrapsychic ones.

One of the strengths of creative workshops for child survivors of institutionalized violence is their cultural adaptability to different needs and expectations of emotional expression and suppression (Apfel & Simon, 1995). Boothby (1994) introduces therapy options such as projective drawing and storytelling to support the child to relive the traumatic event, describe its worst moment, and gain some measure of control over the experience. Group sessions that involve drawing, storytelling, role playing and other activities that provide an opportunity for the expression of fears can support a process of trauma resolution. Boothby (1994) is careful to point out that in countries where the government is repressive, psychosocial treatment programs need to be deinstitutionalized, thereby advocating a community-based approach:

> not only because of the socially-based nature of the problem, but also because of the severe lack of human and financial resources available for individual treatment. Thus, outside assistance needs to be based on a careful examination of how a given population is coping on its own with the fear, danger, and extreme poverty engendered by war. The introduction of new or socially discrepant structures into societies affected by war should be avoided whenever possible because it can tilt the often precarious balance of survival away from community-based solutions and toward less responsive, centralized ones (p. 252).

Garbarino (1990) adds that the therapy of choice reassures the child that she or he is safe again.

Baron (1994a) has developed an innovative model for helping child victims of violence by using a combination of storybook, companion discussion guide and community training workshop. The underlying theme of the storybook ("A Little Elephant Finds His Courage") is the promotion of self-reliance as a way of combating the helplessness that exposure to violence can generate. Because children of war often have no outlet for their hurt and fears, feelings of insecurity take on a life of their own. The storybook is a way of addressing loss, death, grief and acceptance. It is intended to support families by providing an easy-to-use practical tool for facing issues that are often left unspoken.

While Baron's storybook was developed in Sri Lanka and tested in communities there for eighteen months, she sustains that it is adaptable to and has been used in the most varied cultural contexts throughout the world. Part of its success may have to do with the medium: storytelling is an ancient and universal art. It is distributed in rural villages through non-governmental organizations that receive training from the author about the emotional needs of those who have been exposed to violence and experienced loss, as well as a review of the book materials and practical helping skills. Local trainers then provide parent educational seminars that utilize the book as the central tool. Follow-up meetings are held with parents to talk about their feelings and the experience of reading the book to their children.

In addition to its effectiveness and adaptability, Baron's work is significant because it is part of a trend in posttraumatic field work to develop materials of a psychoeducational nature that are applicable to community environments where the overwhelming majority of the people have been exposed to traumatic stressors. Part of Baron's contribution (1994b) is her integrated approach to recovery which emphasizes that the child's interests are inseparable from the family's needs, including economic needs and survival needs, as well as psychological and physical health needs.

Macksoud (1993) has developed a manual to help parents and teachers understand and deal with children's responses to war. While not intended for those most severely traumatized, it is an important source of support and guidance for communities and families that are intact enough to aid children who are exhibiting normal responses to trauma.

UNICEF (1990) in Sri Lanka has created a manual for trainers working to prepare field workers in areas of conflict. Employing a distance education approach, it is designed to assist children in isolated regions who are suffering from the consequences of violence and conflict. The strategies the model proposes are community-based and encourage mutual support. Through case studies and the posing of key questions, the manual provides caregivers with basic developmental information, and offers ways to help children express emotion and form new relationships in order to overcome trauma.

By encouraging adult caretakers of child-survivors to train others to implement this work, the ranks of the community of adult caregivers increase, thereby decreasing the risk that they themselves become overwhelmed and immobilized by the children's painful stories and degree of hurt. Ayalon (1982) defines the systematic care of caregivers as necessary to prevent secondary trauma insofar as "...children are being cared for by adults who have been directly affected by the same violence affecting the children, or by people coming from the outside (as international relief organizations) who can easily be overwhelmed

themselves by the immensity of what they see and hear, especially the experiences conveyed by children" (p. 29).

Mollica (1989), while referring to healing of children in Cambodian refugee camps at the Thai border, points out the importance of hearing traditional tales, learning traditional healing methods, and helping children recognize that they are connected to something older and bigger than themselves, their parents and their current pain.

Jareg (1995a), Richman (1993), and Apfel & Simon (1995), all of whom work with children traumatized by war, agree that psychosocial programs need to pay attention to resources and resiliencies rather than symptoms. Children are best assisted when the needs and resources of the family unit are addressed. Jareg (1995a) clearly advocates identifying and supporting local coping strategies as a point of departure for successful intervention, instead of imposing external models. Knowledge of local culture and traditions is identified as critical. The central tasks to be addressed in a healing process revolve around the creation and maintenance of a place of safety, reestablishment of trust and self-esteem, attachment and the prevention of separations, and the fortifying of social, cultural, historic, spiritual and sexual identity.

Empowerment and participation are the underpinnings of effective therapeutic interventions for helping children, young people and communities cope with trauma (Jareg, 1995b). Jareg points out that it is important to open a dialogue with children about what is particularly distressing to them, how their lives have been changed by distressing events, whether they are being met with understanding and support from adults in the family and community, what would be helpful and whether they have access to such help, what they are doing to help themselves, and how they want to be supported.

Games allow children to relive trauma safely and reframe the painful experiences by giving them a different ending and thus healing themselves. With children and adults art therapy opens a gateway for

accessing those memories lodged in the brain's amygdala that replay themselves, causing the trauma victim to experience intrusive recollection (Goleman, 1995).

2.4 Conclusions

A wide spectrum of theories and methodologies contribute to a deepened understanding about the nature of recovery and the multitude of pathways toward healing. While not drawn from the same models and approaches, the following are some key points from the literature which complement one another as facets of relevant strategies and guidelines for the treatment and healing of trauma victims. They include:

- victims benefit from learning about the characteristics of trauma-induced stress responses;
- victims who suffer from feelings of disconnection and withdrawal derive healing from developing a relationship with caregivers who are accepting and nonjudgmental;
- caregivers may need to take a stand by voicing their personal opposition to and disapproval of whoever or whatever caused the victimization in order to gain and merit the victim's trust;
- the careful building of safety is key to the successful outcome of therapy;
- victims benefit from re-establishing interpersonal connections with the social support they have lost;
- social action and advocacy can be beneficial to victims recovering from traumatic exposure;
- cultural differences between caregivers and victims can curtail the success of treatment and even retraumatize victims;
- secondary trauma needs to be expected by therapists working with trauma victims and its impact can be lessened;
- transference reactions by victims may replicate the dynamics of the traumatic event;
- countertransference reactions by therapists can be strong and need to be understood;

- the physical body holds part of the traumatic memory and needs to be worked with in the recovery process;
- the physiological symptom of hyperarousal can be overcome as the brain relocates the traumatic memory into a more normal memory storage bank;
- traumatic exposure challenges a person's basic assumptions about self and the nature of the world, and recovery implies a rebuilding of assumptions that can incorporate the traumatic experience;
- art therapy and expressive techniques seem to open doors toward healing that are not easily passable with other tools;
- the period of postvictimization affects people differently according to their age, the meaning their culture attaches to the kind of stressor they were exposed to, their level of social support, and the quality of the person's relationship to their community.

Most current treatment and recovery approaches reflect a belief in the sagacity of healing individuals in the context of community. According to some practitioners, frameworks that grant equal footing to the economic, political, social and cultural realms that both caused the trauma and in which the traumatic exposure happened increase the victim's possibilities of healing in community. Harvey argues that:

> The existence of large numbers of persons who either do not use or do not benefit from clinical care suggests the need for community-based studies of trauma recovery and resiliency in untreated survivors as well as a need for more and more effective community intervention efforts. For example, public education activities that reach out to a broad public with information about trauma and violence and that explain and normalize many of the psychological sequelae of traumatic events augment the efficacy of clinical interventions. For some individuals, these interventions may have far greater impact than clinical care (p. 20).

There is increasing evidence around the world from South Africa [2] to Russia [3], to Bosnia and Croatia [4], the United States [5], to Latin America [6] that community-based treatment models are effective in the rehabilitation and healing of those exposed to the terror of war and violence. Traditional psychiatric tools for assessment and treatment can greatly inform and strengthen community-based approaches and need not be underestimated in importance. At the same time, the increased use of para-professionals can do much to attend to the wounds of untold numbers of civilians, many of whom have suffered from prolonged exposure to chronically traumatizing events and are geographically, culturally, or spiritually out of bounds for the available professional care. No doubt, as the role of para-professionals in the healing of war-induced trauma gains increased recognition, new forms of assessment, treatment and healing will be uncovered and shared with the entire community of those moved to work with victims as they become survivors.

---

2 note the work of Dr. Peter Lang with para-professional mental health workers in his native South Africa.

3 note the work of the Russian Mothers' Soldiers Committee and its efforts to rescue and rehabilitate Russian soldiers who were forcefully conscripted into the Russian army to fight in Chechnya.

4 note the work of the Women's Commission on Refugee Women and Children (based in Boston) of the International Rescue Committee and its supply of yarn to women's knitting groups in refugee camps where gradually women share testimony; in effect, knitting has become a mental health tool.

5 note the work of family therapist Rhea Almeida who uses a psycho-socioeducational model and lay assistants in the rehabilitation of male batterers.

6 note the work of Lykes et al. in Central America.

PART 2
A CASE OF COMBINING EDUCATIONAL AND THERAPEUTIC INTERVENTIONS

INTRODUCTION

The Central American mental health workers training program was comprised of several components: an educational curriculum for knowledge and skills acquisition; a group integration process, fostered through the systematic sharing of knowledge, skills and experiences among participants; strategies and exercises for the establishment of safety and trust; application of conflict resolution techniques; rendering of group support to individual expressions of emotional pain; and extra-curricular interventions to support individual and group healing efforts. And yet, due to the convergence of these factors, the program was much more than the sum total of its individual parts. Through the creation of a supportive yet challenging environment, a continuous flow of optimism, personal attention to participants' needs, and an unwavering belief on the part of staff in the successful outcome of the intervention, something much greater happened. The impact of the training transcended the cognitive realm. Trainees endeavored in significant emotional release. Before their return to Central America, participants expressed feeling a sizable boost in self-knowing and ability to be agents of change in their own lives, those of family members, and in their communities and institutions. Participants gained new learnings about psychological traumatization, acquired important skills and techniques in the areas of community mental health, leadership, communications, and conflict resolution, and underwent a process that encouraged the shaping of a new sense of self.

The two chapters that make up Part 2 address different aspects of the case study: its background and curricular design, the unfolding of the actual process, and the issues raised by the intervention. It is our hope that this section goes beyond explaining what occurred during the eight

week training program to offer the reader some insight into the 'why' and 'how' of this particular experience.

CHAPTER 3
CASE STUDY DESIGN

3.1 Introduction

This is a study of an educational intervention that surpassed its original mandate to provide cognitive training in community mental health. The case is a program designed for twenty-four village-based mental health workers from one of the Central American republics [7]. They were trained in the United States by the Institute for Training and Development (ITD) of Amherst, Massachusetts during eight weeks in the spring of 1994. As co-director of the training program, I was responsible for the curricular design and delivery of most of the training.

While technically a nonformal education endeavor, the training program anticipated a need for significant therapeutic and conflict resolution components. However, the extent to which these interventions were necessary was initially underestimated by ITD staff.[8] This paper narrates the evolution of the technical training program and analyzes how trainees were provided with therapeutic support as well as an environment that encouraged them to address their mutual animosity due to their very different roles and positions in their country's civil war.

My original goal was not one of psychological rehabilitation of the trainees, for this implies the need for something to be remedied. Rather, by introducing a therapeutic option which supported witnessing and emotional release, my intent was to contribute to the process of empowerment work. The rationale behind this strategy was a belief, that in the aftermath of war, human suffering either constitutes an opportunity to bring people together or becomes justification for further isolation and deepened distrust. By definition, war engenders separation

---

[7] To further protect the identity of the participants, no mention is made of their specific country of origin or institutional affiliation.

[8] Some of these interventions were part of the official program curriculum while others were offered as optional activities.

between people. How to transform this situation into greater self-knowing, self-care and interrelatedness is the key issue. The creation of an atmosphere of interactive growth was needed to overcome individual pain and separateness, and to further personal as well as social healing.

This melding of the educational and therapeutic realms raises a crucial question about how and under what conditions therapeutic intervention can effectively situate itself inside an educational context.[9] Given the alarming degree to which the trainees had been exposed to traumatizing experiences (87%, according to interviews conducted prior to their arrival in the United States), it seemed imperative to offer individual psychotherapy to all participants.[10] This option was presented to them as an opportunity to address personal concerns, conflicts, and issues before returning home to provide psychological support to community residents. The dynamics of vicarious trauma were explained to the participants as a real danger for mental health practitioners who ignore, avoid or postpone their own healing in order to serve others. What's more, it was pointed out that one of the ways therapists learn their trade is by doing their own therapy. This is the best way to avoid confusing their own issues with those of their clients. Nearly half the group (eleven out of twenty-four) chose to work with psychotherapists while in the United States. Once the program got underway and many participants began to experience first hand getting psychologically triggered by the curricular material, other trainees expressed interest in having individual therapy sessions. The latter demonstrates how this provision was seen by the participants as an important safety net during the intervention.

The decision to offer and in some cases encourage therapy for participants was, however, an exceedingly delicate one. What if our well-intentioned yet short-lived efforts opened up the participants to painful

---

9 I am referring to the balance between what kinds of issues are appropriately raised during training sessions, and which ones are preferably dealt with therapeutically outside of training sessions.

10 The rationale for offering therapy to all participants and not just those who reported having had traumatic experiences is that denial is a legitimate coping strategy, and perhaps not all participants were initially willing or able to divulge the fact that they had been exposed to traumatizing events.

memories and unresolved issues which they would not be able to adequately address and work through? Their two-month stay in Amherst was clearly not long enough to consolidate a healing process. Would an incomplete experience leave them more vulnerable than before because of a heightened awareness of their personal situations, a common by-product of therapy? Was it irresponsible and reproachable to even tamper with their own coping mechanisms that had obviously carried them through the armed conflict and its aftermath with some degree of success? Could outsiders assume to know anything relevant or helpful about another culture's way of dealing with the kind of trauma unleashed by wars they themselves were not exposed to? In our intention to help, could we avoid projecting onto the Central Americans our own meaning-making of the war and the way it affected both civilians and combatants alike? These were some of the preliminary questions that carried me into the training program and the complex task of creating a modicum of safety for the participants. Unfortunately, most of them cannot be answered adequately at this time, due the absence of a follow-up study.

Another primary concern highlighted by this experience had to do with the appropriateness, or inappropriateness, of the diagnostic category of posttraumatic stress disorder (PTSD) and treatment strategies for people from grass roots communities in developing countries. The category of PTSD was created by the psychiatric profession in the United States following the Vietnam War. Although not exclusively intended to assess and treat veterans suffering from psychological disorders related to their war experiences, its inclusion in the Diagnostic and Statistical Manual of Mental Disorders can be traced to the overwhelmingly high number of Vietnam veterans psychologically traumatized by their war experiences. The revelance and adaptability of the PTSD category to other contexts and population groups is subject to much debate.

3.2 Background: The Request for Proposal and Pre-Departure Visit

In December 1993 ITD was invited to bid on a Request for Proposal (RFP) to train Central American community mental health workers, primarily from the former war zones of one of the countries in the region. According to the RFP, attention to the population's mental health needs has not traditionally been viewed as a priority in the region. The civil strife and wars left people in desperate need of mental health services while simultaneously weakening the infrastructure necessary to provide them. A disproportionate number of individuals who require these services live in the former war zones of their country, mostly rural areas which were directly impacted by the violence. Residents of these areas, in particular, suffer war-related trauma coupled with the stresses of rural poverty.

Two Central American organizations were identified as appropriate sponsors for participants in the training program, one a public entity that provides health services to the population (Group A), and another a private institution that has a training program for mental health para-professionals (Group B). Both organizations were responsible for providing a pool of candidates for a selection process that lasted several months. The purpose of the United States-based training was to provide village-based para-professionals with the knowledge and skills necessary to attend to the growing psychological needs of the country's rural population.

The overarching objective of the training as stated in the RFP was to provide participants with a basic understanding of mental health principles and intervention measures so they could develop their potential as mental health workers and change agents in their communities. Specific objectives included preparing participants to: apply preventive mental health strategies and basic intervention techniques; facilitate participatory diagnosis of community mental health problems; form peer support groups around specific mental health needs; design and

deliver educational talks to strengthen their community's emotional health and well-being; become stronger leaders and motivate their communities to support mental health strategies; practice healthy communications skills and contribute to conflict resolution; and, train others in their communities and organizations to support mental health efforts and activities. Upon their return to Central America, the overall context of work for the trainees was to fill the void created by the scarcity of professional psychotherapists in rural areas; most are not involved in the provision of community mental health assistance to the rural population.

The ITD proposal argued the existence of a link between participatory democracy and mental health. A psychologically-traumatized people may have difficulty feeling part of the civic life of their society. And yet the long-term success of the Central American peace process depended to some degree on the population's readiness to embrace not just democratic structures and procedures, but also democratic behaviors. Democratic behavior, both at a national and local level, requires a willingness to cooperate for a higher common good. In some situations, the impact of civil strife and war can leave people without a sense of connection to their communities or even families. When trauma has been experienced, the psychological makeup of the self and its attachment to others can be undermined. If this situation affects a significant portion of a community comprised of people already strained by the reality of rural poverty, the possibilities of creating healthy, vital communities willing and able to cooperate with one another are diminished.

The creation of community-based systems of peer support is a strategy to foster both psychological and social healing at the village level. The ITD proposal addressed the highly centralized nature of the country's mental health profession, and the breadth of need for care in the rural ex-conflictive zones. The proposal also focused on the development of community-based strategies for fostering mental health and well-being of local communities. The strengthening of leadership skills and grasp of non-formal education strategies and methodologies would enable the

participants to convey their newly gained knowledge and skills to peers and colleagues back home. The role of the family would also be examined due to the enormous impact that significant others can have on the healing process of the survivor. The high degree of probability that family members were also traumatized was acknowledged and considered an important factor in the overall context of work.

Upon notification of ITD's contract award, I traveled to Central America for a pre-departure orientation workshop with participants. My intention was to: 1) interview each individual participant, with particular emphasis on detecting the presence of untreated psychological trauma; 2) observe the in-country training provided to the participants in basic mental health concerns and concepts; 3) visit several of the participants' villages to have a first hand experience of local conditions, needs and resources; 4) share information with the participants about my personal history, professional interest, and role in this training program; 5) meet and talk with representatives from the two sponsoring institutions about their aspirations for the United States-based training program and the nature of their commitment to the trainees upon their return to Central America. This last issue was of great concern given previous ITD experiences with sponsoring institutions that imposed unrealistic quantitative expectations on returned trainees, which undermined their ability to creatively adapt their U.S. experience to local conditions.

An interview instrument was designed to gain information about each trainee's relationship to their work, experiences during the war, and expectations of the U.S.-based program. Each interview was 45 minutes in length, during which time I tried to create a comfortable and relaxed atmosphere. This included emphasizing that the interview's sole purpose was to better serve the participants by providing their U.S. staff with a comprehensive picture of their hopes and needs. To avoid transmitting an air of formality in the interviews, I chose not to tape record the conversations, but rather took notes. The questions of the interview instrument were:

1) If you had to define two things you would like to learn in the U.S. to improve your work at home, what would they be?
2) How would you define your greatest work-related achievement ?
3) Describe a personal learning that has touched you deeply. How did you learn this? Once you learned it, how did you apply the learning and what impact has it had?
4) What is the obstacle you most frequently encounter in your work? In a best case scenario, how do you overcome it? Which attitudes and behaviors help you in this process?
5) From work with other people from your country, we have found that many were exposed to traumatic experiences during the civil war. In your personal case, if you have had traumatic experiences, have you gotten support or help from anyone? Has there been anyone to speak to if you've felt so inclined? If you could create a supportive environment for yourself during your two months in the United States, what would that look like?
6) If you were to name one personal learning that you'd like to take away with you from your experience in the United States, what would that be?

The interview results revealed a remarkable group of highly committed, creative and enthusiastic people with a wealth of personal as well as community-based knowledge. Participants shared an unwavering, almost mystical dedication to community service, spiritual strength, and significant exposure to painful war-related experiences. Many had been victims of violence and abuse previous to the war, and seemed grateful to be offered the choice of working with a psychotherapist while in the U.S. In hindsight, I can see the appropriateness of their tentative responses during the interview process. It took weeks for the fuller stories of war and abuse to be told during the training. Those initial interviews exposed the "large tip of a gigantic iceberg," enough to motivate my thinking about how a safe container for the work to come could be created.

My field visits to local communities were important since they revealed the variety of work done by the participants from the two

sponsoring institutions. They also indicated the significant distinctions between the two sponsoring institutions. The participants from Group A were salaried health workers from a strictly-regulated hierarchical public institution that emphasized quantitative output by stipulating the number of weekly visits each health worker had to pay to rural households. Because the focus of these visits is pre-determined, they do not lend themselves easily to an effective community mental health model. The Group A participants were being sent to the U.S. to expand their knowledge and skills of physical health to include mental health. It is noteworthy that participants from Group A did not choose mental health as a career path; rather, it chose them. Although the Group A participants had voluntarily become health workers (and done so with great enthusiasm and commitment), none had done so knowing they would be asked to broaden their field of knowledge and skills to the realm of mental health. This is significant because it is often the case that individuals choose mental health as a vocation because of personal experience or interest.

The geographic distance between the work sites of each Group A health worker was large enough to leave me wondering if, upon their return from the U.S., they could easily attend team meetings to support one another in the implementation of their village mental health strategies. I also wondered if their institution would grant them permission to allocate time from their busy work schedules for their on-going healing and peer support endeavors.

The Group B sites I visited were highly organized communities of mostly ex-refugees who, while in exile, created self-regulated settlements with a multitude of community-controlled projects. As the threat of political repression in their country subsided, these refugee settlements relocated from the host country to their country of origin. Unlike their colleagues from Group A, the Group B participants had chosen the mental health vocation, and it seemed as though, upon their return from the U.S., they would have more of an opportunity for innovation and personal initiative in their community endeavors. However, as mostly

unpaid community service workers, their work plans were subject to community approval. And, in this case, for ideological and political reasons, recommendations made by them as ITD-trained mental health workers might be disqualified because they were 'Made in the U.S.A.'—the superpower responsible for arming, funding and training their enemies in the armed conflict. Although the Group B mental health workers had more relative autonomy in the visioning, planning and implementation of their work as compared to the more strictly controlled Group A health workers, it was unclear they would be supported in the local application of the skills, techniques and strategies acquired during their U.S. training program.

During one of my field trips, I unexpectedly met the sole survivor of one of the most brutal (and due to her, one of the most well-documented) massacres in the Central American region. Hundreds of peasants had been lured by the army into a village with false promises of safety from combat between government forces and the insurgents. This woman was last in a long column of mothers and girls being led off to execution when a disturbance at the front of the line momentarily distracted the rear guard. According to her testimony, she slipped off the line, hid behind a tree before the soldier returned, and while trying to burrow her way into the earth for camouflage and protection, heard the U.S.-trained battalion slaughter her husband and each of her children, and others. She told me her own psychological survival can only be attributed to the strength of her spiritual beliefs and the opportunities she has been given to offer testimony around the world. Information and perspective gained from this chance encounter confirmed the importance of anchoring the ITD training experience in the spiritual belief systems of the participants while at the same time offering opportunities for testimonial sharing.

Regarding the information I shared with participants about my personal history and professional interests, I told them about my experiences in Chile and how they had shaped my professional choices and inclinations. I introduced myself as an educator, therapist, researcher

and survivor of psychological trauma from political violence. I stated openly that I was not neutral when it came to political repression, violence and the social injustice that engender them. I also indicated that my experience with scores of community leaders from Latin America had taught me that psychological traumatization has social origins, that personal and social healing lay at the heart of community building, and that distrust can be overcome in the arena of group process. I informed them of my doctoral research and asked their permission to study our process together, which they granted. Before my return to the U.S., I met with high-ranking officials from both Groups A and B, and noticed some resistance on the part of a Group B representative to the inclusion of posttraumatic stress disorder as a curricular topic. I understood this response as a rejection of the PTSD diagnostic category, given its stigmatization of people as disordered, therefore making it more difficult for them to reintegrate into society. I tried to assure the Group B representative that the emphasis of the training program was on fostering healthy emotional skills and capabilities, not on pathologizing people for their response to the atrocities of war and social violence.

3.3 Training Content and Curriculum

Upon my return from Central America I revised the eight week training curriculum to include the following general themes, and their respective subtopics and learning activities:

Week 1: Orientation: Welcome.
Introductions of Participants and Staff.
Revision of Program Goals and Work Methodology.
Logistical and Administrative Information.
Hopes and Fears Exercise.

Sharing with participants results from Needs Assessment and Interviews conducted in Central America:
Who are we? Where are we from?

What knowledge and skills do we bring to this training?
What are our strongest capabilities?
What are our greatest achievements?
What are the major obstacles we have faced?
During the war some of us experienced...
What do we want to learn in the U.S.?

Safety, Trust and Container-Building Guidelines:

What is our shared purpose?
What do you most value in life?
What kind of a community do you want to be part of during the next eight weeks?
Make a list of ten guidelines or norms that you want your community to honor.
Vessel-making: exercise with clay.
Is there something you want to hold in your vessel or container? Personal reflection exercise.

Characteristics of mental health in our communities:

T-Chart: (Influencing Factors–Problems).
Community Mapping: history of 'talking maps'; maps as tools for community diagnosis and education; small group application of technique; large group discussion and analysis.

Problem Analysis Techniques:

The 'Why' Chain.
Problem Trees: differentiation between causes and consequences; small group application of technique; large group discussion and analysis.

Week 2: Leadership training:

Leadership Styles: (brainstorm; role play).
Aspects of life where we exercise leadership.

Leadership in our work: (T-Chart application).
Our roles as promoters/Attitudes we want to have.
Ten traits of a good leader: (personal reflection; small group work; large group discussion; personal assessment; small group feedback and recommendations).

Communication Skills:

Common communication problems at work and at home (group discussion).
Listening Skills.
Use of "I" statements.
Giving and receiving feedback.

Team-building

Nature of groups.
Groups I belong to (brainstorm).
Characteristics of groups that succeed and fail.
Maintenance and Task Behaviors.
Groundrules for groups.
Participation and decision-making (role play).
How to motivate and run meetings: (simulation).

Conflict Resolution

Personal feelings about conflict: (brainstorm)
Conflict as opportunity.
Different types of and responses to conflict: (role play)
Creating safety for conflict resolution: (small group discussion).
Dialogue Skills.
Finding a common interest.
Clarifying your own position; looking for neutrality; taking the other side.

Resistance to Change (personal and group)

Strategies for identifying it (continuum chart).
Strategies for addressing it (group brainstorm).

Group Dynamics:

Stages in group development: (case studies).

Week 3: Family Therapy and Systems Theory

What is a healthy family and how do its members behave: (personal reflection, brainstorm, discussion).
The family as system; counselors as part of the system.
Roles, subsystems, hierarchy, coalitions, boundaries.
What we learn about the world in our families.
Different family styles and the role of culture.

Psychological Trauma, Assessment and Counseling

Stages in human development.
Nature of Psychological Trauma.
Primary and secondary symptoms.
Types of posttraumatic stress.
Precautions for caregivers.
How to do a psychosocial diagnosis: (simulation).
Interviews and assessment: (small group work).
Trauma Questionnaires: (small group application).
Different kinds of problems and treatment.
Stages of Recovery: remembering, grieving, reconnecting; safety and self-care.
Community approaches to PTSD.
Sandbox Technique: (explanation; small group application).

Week 4: Expressive Art Therapy

Why art as therapy can heal trauma.

Steps in recovery process.
Beliefs that sustain trauma; beliefs that heal trauma.
Individual application of techniques.

Child Sexual Abuse

What is child abuse and what are its myths?
Adult responsibility.
Indicators of child sexual abuse.
Community-based treatment strategies.
How families and society teach sexuality.
Child sexual abuse and suicide.
Prevention Strategies.

Substance Abuse

Dependence and abuse.
Stages in alcohol abuse.
Physiological, emotional and social effects.
Classes of substances.
Acupuncture and substance abuse.
Drug abuse and AIDS.
Prevention.

Social Action, Advocacy and Legal Concerns

The Culture of Silence: how to break it (brainstorm).
Attitudes and behaviors we need to change/ strategies for changing them: (T-Chart).
Social Action: (role play).

Mid-term Evaluation: (quantitative and qualitative)

Weeks 5-6: Internships at Boston-area community agencies

Week 7: Nonformal Education and the Multiplier Effect

Education and learning.

How adults learn: experiential learning cycle.
Characteristics of effective educators: (brainstorm).
Training Skills: those I use, those I've observed, those I want to learn more about.
Design of mini-training session: (small groups).
Social Marketing.

Action Plans for Community Intervention: preliminary design

(small group work).

Week 8: Crisis Intervention

Factors that contribute to high risk.
Therapeutic Interventions.
Role of Social Support.
Follow-up.

Departure and Reentry

Guided Visualization: a promise I make to myself; anonymous sharing.
Hopes and Fears about returning home.
Reentry to home and work: (four role plays).
How to be enthusiastic without alienating peers: (simulation).

Action Plans for Community Intervention.

Final Evaluation: (quantitative and qualitative)

The entire curriculum was discussed and negotiated with the participants upon their arrival from Central America. Each week of training began with a review of the training calendar and adjustments. For the most part there were weekly visits to local community mental health sites and community-based organizations. Participants engaged in cultural

activities during the evenings and on weekends. All trainings were held in Spanish except for some of the extracurricular activities that required simultaneous translation. Brief formative evaluations were held weekly. Longer evaluations took place midway through the program and upon its completion. Evaluation formats varied but, for the most part, combined qualitative and quantitative methods. Participants evaluated their training experience with regard to content, trainers, methodology, support material, applicability to the Central American context. They also assessed the program's interpersonal dynamics, both among themselves and with staff. Final evaluations focused on curricular areas and stipulated training objectives.

3.4 The Rationale behind the Curriculum

The curriculum was designed to allow continuous opportunities for container-building.[11] Container-building implies the joining together of individuals to create a shared group identity in order to foster an atmosphere of safety and trust that allows for self-disclosure, personal work, conflict resolution, and/or emotional risk-taking. The intent was to build a setting that could contain powerful emotion so the group and its members could work through difficult issues. This was accomplished not only through trust-building icebreakers and exercises, but through a pervasive attitude of respect for individual needs, and numerous provisions for emotional safety.

At the outset of training the participants were given the results of the individual needs assessment and interviews conducted by me during my pre-departure visit to their country. This was the training program's first step from being a disparate gathering of individuals to becoming a group with shared identity. Then, each participant contributed to a general analysis of the Central American social reality and its impact on the

---

11 see Markova, D. (1994). *No Enemies Within.* Berkeley: Conari; and, Paul, M. & Schley, S. (1994). "Developing a Multicultural Learning Organization." *Systems Thinker,* 5(8).

mental health of people in their communities. This information was used to anchor the U.S.-based training intervention in the characteristics of the people it purported to serve. It also helped to validate individual participant contributions, socialize them, and thereby open a roadway into experiential learning and participatory process.

The decision to address early on in the training calendar the topic of leadership training was based on the belief that group process would be strongly influenced by individual leadership styles. Given the polarization within the group of the two sponsoring institutions caused by distinct identities and work styles, mutual perceptions of distrust, and varying levels of animosity, these could negatively influence the participants' ability to join together in a learning venture. Therefore it became apparent that before addressing content topics regarding mental health and psychological trauma, it was critical to introduce topics that would raise issues and provide skills for improving the inter-personal dynamics among the participants. The training sessions on leadership focused on the meanings of leadership, its different styles, and the facets of life where it is exercised. A guided visualization was conducted so that each participant could evoke for themself an image of 'leader' and discern this person's characteristics and guidance. An individual writing exercise followed, and lead into small group work to consolidate the separate lists into one. This process was repeated in the large group until consensus was reached and a list of fifteen characteristics was agreed upon. Then each participant did a self-appraisal based on these characteristics, indicating in which they felt strong and in which they felt weak. The exercise ended in small self-selected groups based on a high degree of trust. Group members provided each other with feedback and recommendations about how to strengthen those characteristics they deemed their colleague needed to reinforce.

The topics of communications skills, team building, and conflict resolution were also addressed early in the program, based on the assumption that they tend to bolster group integration and container building, as well as specific skills acquisition.

I intentionally chose to cover psychological trauma in week three of the curriculum, believing that the group would be strong enough to support its members and those desiring it would still have substantial curricular and extracurricular time to work on the emotions and issues that such a discussion might raise. The rationale behind the decision to examine sexual abuse in week four was similar.

A two week Boston-based internship experience was designed to expose participants to a variety of strategies, approaches, skills and techniques for community education and mental health, and provide them with opportunities to share their experiences and insights with both practitioners and clients in a variety of settings.

The development of the broad strokes of a community-based mental health model was addressed on the heels of the internships, in the context of the participants' action plans. Nonformal education and methodologies for training others was left until the last week to offer participants an opportunity to begin to think about which aspects and topics of their eight week training program they wanted to share with colleagues in their sponsoring institutions. It also gave them a hands-on experience of designing training sessions, preparing and delivering short presentations, and receiving feedback from their peers and ITD colleagues.

3.5 Training Strategy

The following elements comprised the framework of the training strategy, based on the characteristics of the trainees, the expectations placed on them by their sponsoring institutions in Central America, and the nature of the training program:

1) Continually emphasize the fostering of safety and trust. Include daily trust-building exercises. Introduce tools like "People's Mailbox" and personal appreciation envelopes for participants and staff to encourage intra-group communication.

2) Take every opportunity for individual and group decision-making to restore or reinforce the participants' sense of control over their lives.

3) Conduct physical exercise and activities to help restore or reinforce a sense of presence and safety in one's physical body; explain its restorative benefits.

4) Practice stress management skills such as breathing, relaxation techniques, guided imagery, and body work.

5) Create multiple opportunities for the provision and reception of feedback, and as staff, model well-intentioned feedback.

6) Utilize distrust which arises as an opportunity for group process and a useful reminder of what type of discord might await trainees in their villages. Encourage participants to use their U.S.-based training experience as a laboratory of how to get along.

7) Encourage educator/therapeutic guides to make personal experience and testimony available to participants. Model the democratization of the relationship between participants and educator/therapeutic guides.

8) Establish a non-judgmental atmosphere by fostering an attitude of respect for the experiences participants bring to the training program.

9) Integrate a macro perspective into the training topics and group discussions to underline the role of war, poverty and a culture of violence in the configuration of the characteristics of a people's mental health. Give examples from the history and current reality of the United States. Make sure no one is left thinking this is a 'Central American' problem. Discuss the relationship between war, violence, humiliation and disempowerment.

10) Elicit methods of understanding and dealing with trauma that come from the cultural context of the trainees. Present curricular topics by

integrating elements of theory, prevention, and treatment, with the trainees' specific local experiences of success and apparent failure.

11) Foster an atmosphere of blamelessness. Discuss how blame undermines the taking of personal and group responsibility and inhibits cooperation. Normalize the participants' individual and collective experiences as survivors of war trauma and encourage a depathologization of their self-assessment. Apply cognitive reframing to emphasize that trauma-inducing situations are failures of the system, not the victim.

12) Model self-care and self-regulation. Empower trainees to leave the training room if discussion topics or exercises evoke in them an intense and severely discomforting emotional response. Teach self-monitoring through body symptoms. Encourage trainees to consider to what extent they want to examine personal issues in a given training session; offer them options for keeping curricular topics at a safe distance. Model and emphasize the taking of personal responsibility. Provide crisis intervention as needed. Offer an individualized approach when appropriate.

13) Encourage an attitude of mutual support among participants and the recognition of self in others. Encourage those in need of support to ask for it, and model how to accept it. Discourage the making of comparisons among trainees, particularly focused on whose pain is greater.

14) Acknowledge conflict when it arises and model ways of exposing the larger issues underlying it. Consult the group on how it wants to handle its interpersonal animosities and unresolved rifts. Attempt to reach agreements.

15) Use small group exercises, dyad and triad work to give trainees an opportunity to practice the skills and exercises offered to them in the program.

16) Use role play and simulation exercises to ground group discussions in the Central American experience. Take advantage of the issues that arise from these exercises to better assess the applicability of the theory and skills imparted in the training sessions.

17) Encourage trainees to regulate their own group dynamics, thereby giving them an opportunity to experiment with some of the new leadership, communications, and conflict resolution skills offered in the training curriculum.

18) Encourage team building among trainees to accomplish curriculum-related as well as community-building tasks and thereby foster a collective learning environment. Clarify that the theory and skills offered are simply a point of reference and that new theories and skills are waiting to be created.

19) Encourage coaching among trainees by modeling it. Encourage educational/therapeutic guides and participants to speak from personal experience and take personal responsibility. Demonstrate the link between personal and group change.

20) Restate the trainees' comments, experiences and insights, thereby validating the information they provide. Model how individual and collective experience can be used as raw material for theory-building. Demonstrate link between praxis and theory. Use this as an inroad toward fostering of group identity through the building of a shared experience base.

21) Integrate body, mind and spirit throughout the training program. Demonstrate how the body and mind are repositories of personal and social experience, and how they co-create one another's experiences. Elicit opinions, insights and experiences on the role of spiritual beliefs in the psychological, physical and social healing process. Encourage participants to use their spiritual belief system in psychosocial healing work, and model this. Create opportunities for rituals of transformation.

22) Provide extra-curricular activities to broaden the skills base and experiential facet of the training program (i.e., lymphatic drainage massage, therapeutic massage, breathwork, acupuncture, acupressure, psychodrama, expressive art therapies).

23) Suggest linkage between the personal, family, community and sociopolitical realms: i.e., what happens inside is a reflection of the larger world and vice versa. Share information and experiences about social and psychological healing by engaging these different levels.

The components of the training strategy reflect a cultural and ideological bias that favors broad participation, personal empowerment, acknowledgment of power differentials and democratization of power relations, self-care, individual and group accountability, belief in the importance of social context issues in personal affairs, and respect for denial as a legitimate coping strategy. In the following chapter we will examine what happened when these training strategies were applied.

CHAPTER 4
CASE STUDY PROCESS

4.1 Unfolding the Training Process: How the Strategies Were Applied

A multitude of measures was taken to facilitate psychological healing of the participants and reconciliation of conflicts between them, the first of which happened one month before their arrival in the United States when I visited Central America. As mentioned, each participant was offered the option of working with a bilingual psychotherapist while in Amherst, so they could address unresolved issues that might get stimulated by the content of the training program, potentially interfering with their ability to participate in it. This was the first provision made for participant healing and safety. Of the twenty-four participants, eleven chose to take advantage of this offer. Once in the United States, more participants decided to pursue the therapy option. The total of fourteen constituted 58% of participants utilizing psychotherapy during their U.S. stay. Of these fourteen, four were from Group A and ten were from Group B. This significant difference might be explained by the fact that Group A participants were just beginning their exposure to the mental health field, whereas Group B participants had a longer and more self-directed involvement in mental health problems and initiatives.

The program began with a number of safety-building exercises and instruments: each participant was asked to stand in the middle of a tight circle with eyes closed, and fall backwards onto outstretched hands; container-building work with clay to shape a vessel to symbolically hold personal feelings and grief [12]; a personal space exercise for individual inquiry into the meaning of safety, boundaries and closeness; brainstorm to discuss and determine the characteristics of the group they wanted to

12 As mentioned in Chapter 3, container-building entails the intentional creation of a shared group identity and purpose in order to support group members in risk-taking, personal work, self-disclosure, offering feedback, and conflict resolution.

become, the values they wanted to embody, how they wanted to relate to one another; and group ground rules, including what, if anything, to do with interpersonal tension and conflict.

Participants were given the option of using the training program as a human laboratory of conflict resolution so they could return to Central America with a concrete and personal experience of useful approaches and effective techniques. Participants were also encouraged to consider using their time together to identify healthy emotional attitudes and behaviors they wanted to foster within themselves, their families, villages and institutions. We discussed in detail what it meant to be posing these questions regarding healthy emotional skills in the United States, far from the daily challenges of their lives in Central America. It was emphasized that answers to these questions might vary according to cultural or social identity, and participant responses needed to be appropriately anchored in the characteristics of the reality awaiting them back home. The group also discussed how unique it was to be examining these issues among twenty-four compatriots, most of whom did not know each other previously and led vastly different lives. They commented on their singular opportunity to 'try to work things out' as a group over the next two months. It was suggested that they might choose to use their attempts at reconciliation and mutual understanding as a learning experience that might be relevant to their future endeavors. At the very least participants would come out knowing what elements do not foster reconciliation and conflict resolution, and at best, they would be able to extrapolate an assortment of attitudes, behaviors, approaches, concepts, and skills that could support a process of individual as well as social healing.

At the beginning of the program, the sharing of personal testimony was introduced as an option for healing and learning. Emphasized was the individual choice to give testimony based on feeling safe and personal readiness. The fact that all the participants came from the same country and, in some cases, same institutions or villages was noted as a potential point of discomfort or risk. Is it safe to speak personally, share testimony, and expose oneself in a group with one's neighbors or co-workers? If one

reveals a history of abuse or personal trauma, can one trust the other program participants to keep this information confidential? This concern reminded the participants of what awaited them back home where in all likelihood they would support and counsel neighbors and perhaps family members, facilitating community-based support groups where people might not feel safe sharing testimony. It also catalyzed a discussion about the very notion of testimonial sharing. Is it appropriate in the Central American cultural context, or does it represent a fundamentally foreign approach to healing? Many participants with substantial experience in community organizations, particularly those tied to the Catholic Church, were of the opinion that testimonial work is a powerful and useful tool for healing and community-building. Others raised questions about the risks of divulging personal wounds in the presence of those who might not be trustworthy. This led to a group conversation about how, in the aftermath of a war, not everyone can be trusted, and the importance of scrutinizing people's intentions and purpose before joining with them in a healing group. As the discussion evolved, I made reference to my experiences in Latin America with the healing potential of testimonial sharing, but pointed out that in my opinion it was not appropriate in all situations, under all circumstances. I took this opportunity to ask them to challenge any technique or concept that felt ill-suited to their reality. This was one of my earliest attempts to address the power and cultural differentials between educator and participants and to legitimize the questioning of authority and cultivating of a critical attitude. The willingness to challenge authority came very slowly, which meant that as trainer I needed to constantly question and remind myself of the dangers of overstepping and abusing my power.

During the program's first week, I told the participants of my personal history in Latin America with social activism, risk-taking, coup d'etats, and trauma-induced psychological stress that went unrecognized by me for nearly twenty years, and how it motivated my participation in this kind of a psychosocial healing endeavor. Based on personal experience, I stated my belief that psychological and social healing walk hand in hand. I also recognized that as individuals and as a people, they

had developed strategies for coping with and surviving the stresses of war. I added that I looked forward to learning from their experiences, and hoped these would be shared by them during the training process. As I began to deliberately expose my biases and values, I encouraged participants to do the same. By rejecting the notion that the training curriculum was somehow scientifically neutral and value-free due to the 'irrefutability' of its technical components, I introduced the idea that beliefs shape individual perception of reality, and this could help us in the building of theory based on our experiences.

To my surprise several participants began sharing personal testimony: one woman, Margarita, talked about the death of her daughter after their house burned down, and how her husband accused and blamed her, beat her and then banished her. She said she needed to be heard and accepted by the group because her pain was like an "oozing wound," and she was afraid people would shun her. Margarita added that her first grade education and scarce ability to read or write made her feel inadequate, intimidated, and fearful of the group's judgment. A few trainees committed themselves to working with her on basic literacy skills, and as trainer I pointed out that participation in the program did not hinge on reading and writing skills. At the end of the second week, Margarita said that she no longer felt intent on blaming herself for her daughter's death, and was beginning to see her husband's violence as a reflection of his own grief and powerlessness.

Soon thereafter, another woman, Alfonsina, told the group that her teenage daughter died of a liver ailment and that our "container-building" work with clay had allowed her to access her sadness and sense of loss without being constantly overwhelmed by the feelings. Many in the group expressed empathy for Alfonsina and Margarita and acknowledged their courage for having come forth with their stories. One participant added that all had benefitted by hearing these particular stories.

However, not all in the program were comfortable with the sharing of personal testimony. One man, Joaquim, felt very relieved by our

suggestion that trainees exercise self-care, including leaving the room if listening to someone else's story proved distressing. Having permission to leave the room on one's own accord was no small matter for many trainees since it was so unlike what some participants were accustomed to.[13] Joaquim expressed discomfort when others cried or told their stories, and as he explained to me during the second week of the program, his own unacknowledged sexual abuse history and great shame made it unbearable for him to remain present during someone else's emotional release. What is significant here is that Joaquim took charge of his own safety by self-regulating what he chose to hear, decided to do personal therapy, and, by the program's end, said, "I couldn't take my eyes off of other people when they shared their tears because each time someone else opened up like that, I opened up a little too and that's how I overcame my own fear of crying."[14]

Another path to healing was provided by the curriculum itself. The design was presented with the following contextual explanation: "Rather than start by presenting you with new skills, we'll begin by asking you to make a sketch of the nature of the mental health challenges and needs of your people. Then you can share with us what tools and approaches are used back home to address these needs, what seems to help and what doesn't seem to help, and we'll share with you some of the theory and tools that have been developed here to address our problems. Ours is not *the* way, it is simply *a* way that has grown out of <u>our</u> particular reality. And mental health issues and problems abound in the United States, so we're not suggesting that our approach provides a solution. But if any of it serves you, please use and adapt it. Let's try to utilize our time together to look deeply at your reality and devise strategies, approaches, even perhaps models to fit that reality. We are here to support you in that process."

Once the program's framework was established, the focus shifted to the first curricular topic, namely, the mental health situation in the

---

13 Some participants shared with me that in their work environment, they are accustomed to using the sanitary facilities during designated breaks, not whenever they want to.

14 Field Notes, May 9, 1994.

participants' communities. Participants were asked to analyze strengths and weaknesses, and to identify the social context factors that contribute to specific mental health problems. This was accomplished with the aid of two specific problem analysis techniques: T-Charts, and community maps.

Following an explanation of T-Charts and the history, evolution, and purposes of community-mapping, the participants were divided into small groups according to their geographic region. This meant that for the first time, participants from the two sponsoring institutions were being asked to work with one another. This is significant for the following reasons: although the Central American participants came from the same country and received the same scholarship for the same U.S. training program, their primary identity and loyalty remained tied to their sponsoring institutions, Groups A and B. As mentioned earlier, these groups differed not only in terms of mission and organizational culture, but vis-a-vis their genesis with regard to the issue of community mental health. Practically all the trainees suffered during their country's civil war, and some participants from each group saw those affiliated with the other group as having contributed to their suffering. From the program's outset, it was clear that the integration of the twenty-four scholarship recipients into a single unit with a shared purpose would be no ordinary undertaking. Participant affiliation to such distinct institutions posed a challenge for the training program. One way to address this challenge was by dividing participants into small groups so that trainees from opposing sides of the armed conflict could sit face to face, exchanging information and outlooks as they attempted to analyze and solve the problems posed by the curricular content and activities.

After a demonstration of the community mapping technique, participants were asked to apply it in their small groups and prepare a community map to share with the rest of the participants. The groups were not told how to make decisions or organize themselves. I wanted to see how they would approach their task. Some groups worked together by jointly discussing the problems and what to draw, while other groups seemed to turn their members loose with no shared discussion. In the

latter case, individuals huddled around large sheets of newsprint, each one sketching in their own corner. This exercise proved an extraordinary instrument for revealing some of the more apparent differences among the trainees.

As each small group presented its map to the large group, I created a chart to list the identified problems, how they have been understood and dealt with. When relevant, it was pointed out how similar problems might be addressed in the United States. During the map-making exercise a conflict arose in one of the small groups where, not surprisingly, trainees from opposing sides of the armed conflict were working face to face, perhaps for the first time. This was one of the groups in which trainees drew in isolation from one another, rather than according to a mutually agreed upon design. A woman named Patricia depicted a soldier shooting people in her village. A man named Ramón objected and asked her why she didn't show a guerrilla fighter shooting people as well. As they became incensed with each other, the training program was visited by its first overtly constellated conflict. I suggested a time-out and privately asked Patricia and Ramón if they would grant permission to use this incident as a group learning experience in conflict management. They agreed and it was presented to the group as a learning opportunity. The group accepted and I suggested we establish some ground rules: no personal attacks and no violence. I asked if we had a shared desire to reach greater understanding of one another from this process, and requested that the participants have a discussion in dyads before deciding. What came out of that was consensus that the "two sides" wanted to better understand one another.

Before addressing the incident, the group had a brief discussion about the relationship between personal and societal belief systems, and the attitudes and behaviors fostered by these beliefs. I asked that each participant examine their own fundamental assumptions about conflict, where upon the group identified the prevailing cultural beliefs about conflict in their country. Then our attention shifted to Patricia and Ramón. This deductive strategy of moving from the abstract to the specific

was applied intentionally to depersonalize the conflict. By establishing a larger sociocultural context, an attempt was made to reduce the probability of blame and increase the possibility of personal and mutual understanding.

At the outset of the intervention, I asked that Patricia and Ramon sit facing one another, make eye contact, and that the group focus its attention on providing a safe container for them. It seemed difficult for them to look at one another. Interestingly, both made reference to great pain, fear, mutual distrust, and feeling unseen and disrespected by the other. Ramón clarified that it was not that he supported the army or the government in the armed conflict, but felt it was unfair for Patricia to brand the government troops as the only culprits. In his personal experience, both sides had committed excesses and atrocities. Patricia defended her position and told Ramón that she had been exposed to the largest massacre in the history of the country's armed conflict. At age thirteen, together with two hundred other terrified peasants, she wandered into a village three days after government troops massacred approximately one thousand people. She literally stumbled upon hundreds of still smoldering, charred bodies of babies and small children. Patricia cried while telling this to the group, as did Ramón for not having imagined what she had witnessed and endured at such a young age. He said he never intended to add to her hurt and apologized. They ended their conversation able to look at one another calmly, acknowledge their personal and shared pain, and exchange a hug. For the moment, the tension had dissipated as they both expressed feelings of relief upon discovering that their mutual hostility had both explanation and outlet.

The mapping exercise also aided in the subtle deconstruction of the isolation of individual story and experience. Once participants heard how many of their colleagues had experienced similar sorrows and difficulties, they began to feel like a group and drew comfort from knowing they were not alone with their memories. A short discussion introduced the after-effects of armed conflict: not only do armed conflicts polarize people into often seemingly irreparable animosity, but they leave survivors feeling

silenced either out of fear of retaliation, or guilt for being alive. The mapping exercise helped place participants' individual selves in context, which in turn, contributed to the slow unraveling of isolation and blame. With this broadened understanding provided by the sharing of personal experience, some energy was freed up for participants to look at how they perceived their life's challenges.

Very early on in the program it was important to establish in some detail, the nature of the participants' roles as village mental health workers, with particular emphasis on what was expected of them, and which fundamental assumptions, attitudes and behaviors they believe would support the most satisfactory fulfillment of those roles. They identified the following as their primary roles:

- counselor/therapists
- change agents in their families, communities, institutions
- educators
- diagnosticians of community mental health problems
- group facilitators
- scribes of the healing process
- bridge between their communities and helping institutions

This exercise created the foundation for the training segment on leadership in which participants identified different leadership styles and brainstormed a list of the most important characteristics of a leader. This also served as an exercise in abstraction through the development of general categories from specific features. Through a process of clustering their dozens of suggestions, and then prioritizing among them, the group was able to define the desired characteristics of leaders as follows:

- dynamic and creative
- friendly
- sincere
- humble
- respectful
- trustworthy and trusting of others
- tolerant

- good communicator, especially good listener
- consistent behavior in private and public life
- able to place themself in other person's shoes
- demonstrate a spirit of service
- responsible
- have good values and demonstrate healthy emotional skills
- discrete
- careful observer

Using this list each trainee conducted a self-assessment, selected two participants they trusted, and then shared the results. In triads, they gave each other feedback on their self-assessments, and generated strategies for strengthening those aspects of their own leadership skills that were less developed. This was an important exercise in personal growth and small group validation. It also afforded an opportunity to strengthen strategizing skills.

Throughout the training program, participants were asked to assess the applicability of the theory, skills and techniques presented to them. Numerous exercises were designed to elicit systematic information about the socio-economic, political and cultural characteristics of their reality in Central America. However, a pattern began to emerge each time the participants were asked their opinion about any of the training themes. Due to the heterogeneity of the group, the rivalry between the two sponsoring institutions, and the power dynamics among the participants from each of the institutions, it came to pass that questions posed by trainers were often answered by the same few people. Those people tended to be the highest ranking (i.e., better educated and remunerated, with higher status) members of each institution.

The participants were most immediately divided by the boundary of their institutional affiliation. Given the implicit hierarchy among both the Group A and Group B trainees, there was a tendency for the highest ranking members of each institution to take on the self-appointed role of speaking for 'their' participants in the group. If trainers asked what the

group thought about a particular idea, technique or problem, oftentimes those with most rank from the two institutions would see it as their duty to 'give the right answer.' One of those with most rank, a man named Manuel from Group B, is a psychologist and the teacher, supervisor and counselor of several trainees. His multiple professional and personal dealings with many of the Group B participants seemed to make him their unofficial spokesperson, thereby impacting on the participatory nature of the training process. Given his professional background as a psychologist, not only was Manuel more familiar with the terminology used in the training curriculum, but his opinions were afforded considerable weight by some in the group.

When asked about the Central American experience regarding post-war healing, those in the group with professional credentials tended to dominate the discussion. This was not inherently problematic because it gave these participants an opportunity to share relevant knowledge. However, it became an ongoing habit that certain participants were the only ones making comments or asking questions, thereby shrinking the possibilities of participation for others. This became a training concern. And yet, as a nonformal education practitioner, I asked myself, am I not imposing my personal and cultural standards of shared leadership and broadened participation on this group by trying to bring this dynamic to their attention? Issues of hierarchy, authoritarianism, and participation are played out very differently in each society. We often tend to identify the imprint of these issues more readily in a culture other than our own. By wanting to democratize the discussions in the training sessions and hear a greater diversity of voices, am I abusing my own rank as program co-director with my assumption that more participation creates a better program? My view on this is that because of the power differential, the potential for abuse exists.

In this case, the dilemma was dealt with by giving it back to the group. For example, one of the group's self-defined ground rules states: "Encourage healthy group participation; everyone should participate and allow others to do the same." By revisiting the group's guidelines we were

able to slowly build awareness about the discrepancy between what they agreed to, and what they were in fact doing. Thus the issue of group accountability and commitment to its own agreements and stated goals became an element in the discussion.

Another example of this contradiction was the training segment on leadership which examined different leadership styles, the role of shared leadership, and its advantages and disadvantages. A discussion began about the degree to which shared leadership was a group aspiration given current circumstances dictated by the training program. In addition, when the 'Comité de Enlace'[15] was created, ITD staff suggested that it be rotational to allow for all trainees to have the experience of serving the community and using that experience to experiment with the application of those skills they deemed relevant.

With regard to the role of the curricular content in the psychological healing process, it made a contribution in that it tended to normalize things for the trainees. By talking about the psychological impact of war as a general phenomena, or citing examples from other countries and historic periods, trainees saw how their reactions to the exceptional circumstances of war and violence were normal and predictable.

An additional level of healing was provided by the extracurricular activities that the overwhelming majority of trainees chose to participate in. One of the intentions here was to strengthen the safety net for the mental health promoters, offer people more and varied opportunities to work on personal issues, and give them an avenue to explore how pain, terror and grief lodge in the human body and effect the nervous and immune systems.

Massage therapy, lymphatic drainage therapy, breathwork, guided imagery, and prayer were the cornerstones of our attempts to bring body,

---

15 Rotating Committee, made up of 3-4 participants every week, to act as the group's liaison with ITD and to facilitate group decision-making.

mind and spirit into the center of the healing process. Through massage therapy, which was taught separately to women and men by same gender professionals, participants examined the connection between emotional field and physical realm of the body. They were shown how to scan their own bodies to locate where they store tension, and offered a detailed diagram of the human lymph system and the directionality of lymphatic flow. The participants were taught the specific drainage points and how to use their fingers effectively. Particular points on the body that tend to harbor grief were identified and participants had the opportunity to observe and practice massaging these areas, as well as the rest of the body. Through lymphatic drainage therapy, they were exposed to the many ways that the nervous and parasympathetic nervous systems influence the immune system, and how to support stress reduction and management through the careful draining of the body's lymph system. In breathwork, twenty-two of the participants worked in dyads [16], taking turns following their breath to release grief and terror from their bodies. For reasons not fully understood by researchers and practitioners of breathwork, hyperventilation through the mouth at regular intervals can activate a powerful and rapid connection between the breather and their deep and/or suppressed emotions. The session began with a discussion about the paradoxical role of the breath: as both life-sustaining, and as the first thing that gets interrupted when human beings are exposed to terrifying experiences. Five facilitators worked with the twenty-two participants who chose to breathe. Several remarkable things happened during the session.

The case of Eliana, a single mother of five, is very telling. Her father was hacked to pieces by death squads during the armed conflict. Those who murdered him placed his head on a stake in front of the family home. After finding him, Eliana and her mother scoured the hillsides, finding and collecting different parts of his body. During the breathwork session, Eliana shrieked uninterrupted for forty-five minutes while a facilitator named Daniel cradled her and encouraged her to stay with her process. After she concluded her emotional release, the look on her face can only be described as angelical. She carefully and slowly looked around

16 Two participants chose not to attend the breathwork session.

at those who had been assisting her. A smile that looked like relief took over her face. Eliana's first words were, "I never thought I'd get rid of these heavy weights I've been hauling around. I feel lightened."[17] A few days later she went ice skating for the first time in her life and conquered the ice with courage and joy, all the while saying, "I could have never done this before."[18]

There were some noteworthy secondary benefits to this particular breathwork session. For example, Daniel, the co-facilitator who worked with Eliana, is an African-American man with dreadlocks who dressed in a way quite foreign to the participants. When we arrived at the session and the participants met Daniel and the other facilitators, they looked uncomfortable and judgmental. And yet, once the work got underway, these attitudes seemed to dissolve. The next day we debriefed the session and discussed how breathwork might be used, the meaning of prejudice, and the distinction between fact and assessment. Many members of the group admitted to having silently labeled Daniel as 'strange' and not to be taken seriously. Some said it had more to do with his attire and general demeanor than his race; others didn't discount race as a factor in their initial assessment. This allowed us to open up a lengthy discussion about assumption-making, the difference between fact and assessment, racism, hatred, inclusiveness, and social healing. The participants acknowledged that Daniel had been exceedingly helpful and were grateful to him for having supported Eliana effectively and unconditionally. In fact, their gratitude to Daniel became a window through which they gazed at and began to examine their own prejudice toward one another and people back home. Some addressed the issue of class prejudice and feelings of inadequacy. A bridge was made from that discussion to their experiences in the United States, how they are treated, what Latino and other people of color have told them about life in the U.S., and how racial prejudice and social oppression are configured in their country.

---

17 Field Notes, May 6, 1994.
18 Field Notes, May 14, 1994.

In addition, the debriefing of the breathwork session offered an opportunity for members of the group to address their fears of other people's pain and grief. During the three-hour breathing session, all twenty-two trainees and five facilitators were in a relatively small room. Somebody else's shrieks and sobbing were never far away. When Eliana wailed, everyone could hear, unless they were completely immersed in their own process. The debriefing discussion that followed created a valuable opportunity for self-observation by each trainee. Some of the following questions were asked: How did I react to other people's suffering? Did I want it to go away? Did I want to fix it? Did I want to rescue them? Did it bring up my own sorrow? Was I able to offer myself as a container to support them in their process, while refraining from wanting to make it all better? The discussion that ensued was a bridge to the examination of some key counseling skills: listen without judgment; refrain from giving advice; do not try to repair things for people; act as guide by asking questions that may lead people to their own answers and choices; trust people's innate abilities to heal themselves. Each trainee had the opportunity to reflect on her/his own answers to these inquiries.

Within the curriculum several problem-analysis techniques and skills were introduced as part of the community needs assessment and leadership training components. Both were used as additional venues to support the participants in the arduous task of reviewing personal experiences in the context of a larger understanding of how war, inequity, injustice, and selfishness impact on and can often explain key aspects of individual life trauma. It also provided an opportunity for pinpointing social issues that directly effect the emotional well-being of people, for example, unemployment and economic despair, political corruption and hopelessness, social violence and fear. We spent considerable time looking at the importance of careful naming of the problem, and how to use community maps to orient a process of problem identification. The practice of clustering and sorting different aspects of similar problems was demonstrated and trainees had several opportunities for application of these techniques throughout the program. What followed were a number

of exercises, for example, the 'problem tree' to help in the differentiation of causes and consequences of a given problem.

The problem tree takes people through a process of inquiry as to the causes of a problem. By using the visual image of a tree to help differentiate causes (root structure), consequences (leaf structure and branches), and the problem itself (tree trunk), the problem tree technique supports the development of conceptualization skills by requiring the identification of causes underneath the more visible cause. It introduces concepts such as structural causes, social causes, political causes, cultural causes, and belief system causes. Likewise, the exercise encourages a search for the larger ramifications of a problem's consequences by moving upward and outward in the tree's leaf structure. Participants in the case study were deeply engaged by application of the problem tree technique. They chose social issues such as women's depression, social violence, war, poverty, and machismo for the elaboration of their problem trees in small groups. The presentation of their findings to the large group unleashed lengthy discussions with a high degree of participation about the fundamental causes and consequences of their pressing social concerns. The participants also learned how to use the 'why chain' to uncover the structural causes that lie underneath the more visible manifestations of a problem.

The training segment on healthy communication contributed to the safety-building as well as skills-building aspects of the program. Effective listening, use of feed-back loops, and "I" statements were demonstrated and introduced as important skills for counselors. The group brainstormed a list of "typical" communications problems that occur in the home, community, and on the job. Then the trainees were divided into small groups and asked to role play some of these problems. A link was established by the group between poor communication and the generation of conflict. Healthy communication was identified as an ingredient of dialogue that can lead to conflict resolution or transformation. Participants were asked to work in dyads with someone they felt friction with or perhaps were avoiding. It was suggested that

between them they choose a controversial topic to discuss and practice reflective listening skills. Each one was asked to state their position while the other listened and only asked clarifying questions. Then the listener summarized the stated position until the teller was satisfied that she/he had been heard.

Later each trainee got to practice the use of "I" statements, in which the communicator is encouraged to take personal responsibility and refrain from blaming by beginning their communication with the statement, "When I observe you say or do ___, I believe___, I feel ___, and that makes me want to ___." They were asked to remember a real life situation of conflict in which they didn't take responsibility for their own feelings or actions, but rather blamed the other person. Using role play they rewrote their own lines by introducing "I" statements.

We also took advantage of this opportunity to discuss the issue of confidentiality in a village environment, and the role of secrets in families and society. The question of rank and power issues and their impact on the counselor-client relation was addressed, with particular emphasis on how gender, social class and education can make it more difficult for some clients of less rank to value their own opinions as much as the counselor's. The difference between a counselor and friend was also examined. We discussed why it is not recommended that counselors work with their own family members, and the role of transference, countertransference, as well as vicarious traumatization as a high risk for them. This led us to a discussion of the strategic role of self-care and peer coaching as tools for village mental health workers and counselors who have been exposed to war trauma. The importance of personal work and peer support for para-professional mental health workers and counselors was identified as perhaps the single most critical component of a long-range viable strategy for village-based mental health work.

4.2 Change Moments: Evidence of Individual and Group Transformation

There were countless instances of individual and group transformation during the program. In one of the last exercises before the end of the training program, participants were asked to make themselves a promise. Common promises were: to refrain from self-blame; to remind myself how much I'm worth; to begin to see others as I want them to see me; to be more self-loving so I can better extend love to others; to be more understanding of others; to stop hating other people; to see the world as it is and not as I want it to be; to forgive the enemy and let go of social resentment.

In addition to these commitments to self, I want to describe in some detail what I choose to call the "change moments" of the program. These were critical instances when a tangible shift in belief system, attitude or behavior was acknowledged by someone and/or between people. When debriefed about their "change moments," people often refer to a shift in their view of self, or view of self-in-relation to others. What follows is a description of some of these moments.

4.2.1 The Case of Patricia in Boston

During two weeks in April the group was in the Boston area interning at a wide variety of mental health and community service sites. In some cases participants were placed at community projects focused on AIDS prevention and education; others had the rare opportunity to observe therapists at mental health clinics serving a primarily Latino population and sit in on group therapy sessions when clients granted their permission. Several participants did their internships at drug rehabilitation programs, and still others joined teams of sex educators as they worked on the streets of high crime neighborhoods. Four of the participants (two from each of the sponsoring institutions) were assigned to five different programs that assist Vietnam veterans in their recovery

from war-induced posttraumatic stress. Our first change moment took place at one of these programs.

Patricia, one of the four participants assigned to these sites, is the woman who, at the age of thirteen, by chance wandered through a remote village scarcely three days after an army massacre of approximately one thousand people. Soon thereafter she joined an anti-government guerrilla organization. On our visit to the Boston Veteran's Center, we had a meeting with three of their senior staff psychotherapists who specialize in the treatment of Vietnam veterans with PTSD. Patricia was sitting on the sofa next to me as I translated from English into Spanish. I noticed that Patricia was quiet during most of the meeting and spent much of the time looking at the floor, but attached no special meaning to this. The therapists, two of whom are war veterans themselves, provided an overview of the services offered by the Center and the therapeutic strategies and models they apply. The Central American participants described the characteristics of their communities, the mental health challenges they face, and their specific roles as service providers. I noticed that for the first time they spoke of the needs of their ex-combatants—both government troops and guerrilla soldiers—as special and different from those of the civilian population. This was significant given the emphasis that Vietnam veterans place on the perils of untreated PTSD in combat veterans. They attribute the alarmingly high suicide rate of Vietnam veterans to this (upwards of 150,000, according to those we spoke to).

Late that evening, back at our hotel, Patricia requested private time with me. I had left this option open to all trainees, particularly those working with psychotherapists in Amherst who would be unable to attend their appointments during our two-week stay in Boston. Patricia was extremely upset and told me that being in the same room with Tim, one of the psychotherapists from the Boston Veteran's Center, had given her flashbacks and brought on an anxiety attack. Tim reminded Patricia of her worst nightmares during the war when she was fourteen and a new member of the guerrilla army. Just as Patricia found her way into the throes of revolutionary activity it was rumored in the ranks of her

organization that an invasion of U.S. troops was imminent. Patricia was terrified. Soon thereafter her first cousin, also best friend and fellow guerrilla combatant, was killed by helicopter fire a few feet away from her. Even though Patricia knew that the helicopter was commanded by Central American military personnel, in her mind she was convinced that those firing the machine gun were from the U.S. because the slaying of her cousin coincided in time with her terrifying fear of a U.S. invasion. Tim, who is well over six feet tall, looked like the invading United States soldier she had so feared. Thus, the trigger.

After hearing her testimony, I worked with Patricia to ground in present time and place. We did some breathing exercises for relaxation. I inquired about previous healing work she might have done around these events. I then asked her if she wanted to use the memory of this terrifying and disempowering situation to empower herself. She said yes, and I asked her to decide what her intention was at this moment. She said what she most wanted was to get over this feeling of fear, helplessness and vulnerability that overwhelms her and use this situation as an opportunity for her own personal healing. We discussed how, by working with what happened on that hillside when her cousin was killed, we might be able to dissipate the impact of the trigger device by releasing some of the grief and anger associated with the loss. Patricia agreed, and I suggested we enlist the support of Tim and the other psychotherapists at the Veteran's Center. Specifically, I recommended the use of psychodrama, and explained it as a technique of enactment in which she would write the script, define the roles, choose the actors, direct the action, step into and out of roles both to partake and observe, and thereby have the opportunity to relive the situation safely and grant herself the emotional release she desires. We had already discussed psychodrama briefly in one of our Amherst-based training sessions, and Patricia said she was willing to try. Late that night I tracked down Tim, explained what had happened and asked for his collaboration. Tim, a former nurse in Vietnam, was very challenged by our request because of his own feelings of guilt for having participated in the Vietnam War as part of the U.S. forces. He said it was painful for him because he felt like he was being cast in the role of bad guy

and enemy. I said that was in fact the case and for that very reason we had before us a singular opportunity for social as well as personal healing. He agreed to help us and contact the other staff therapists.

The next morning Patricia, Juan Pablo, Manuel, Elsa and I returned to the Veteran's Center and reencountered Tim and the other two therapists. We spent considerable time building a safe container together. This was done by clearly stating our individual and collective intentions, asking for each other's support, and asking for divine guidance and protection. I kept my attention focused on Patricia, encouraging her to breathe into the memories as they appeared, while grounding herself in present time. We discussed the psychodrama technique and why it was appropriate given the circumstances, and also addressed its degree of applicability to village environments such as their own. We also talked about the need for norms and safety when conducting psychodrama, and for symbolism so that people can face their painful memories and perpetrators (if that is the case), and in a ritualized way, seize control over episodes in their lives when in fact they felt powerless. A pile of newspapers was brought into the room in case Patricia wanted to symbolically rip the helicopter artillery soldier to pieces. Her role was established as director of the action, in charge of casting, and telling people what to do and say. We emphasized the importance of time-outs to check in with her as to her changing needs and possible shifts in the scope of what she wanted to accomplish or experience.

Patricia decided to set up the scene by first explaining to us how she and her cousin grew up together. She described how at age thirteen they both wandered with two hundred other dazed, hungry, exhausted and fearful peasants through a village that had been the site of the worst massacre during the country's armed conflict. Soon thereafter they both decided to join the guerrilla army and went through their military training together. Eventually they were assigned to the same military unit and did their best to look out for one another. Patricia narrated how their unit was attacked suddenly when a helicopter descended upon them. As they scrambled for cover into the bushes, her cousin was pinned under

machine gun fire and riddled with bullets. She asked Tim and the other male therapist to play the helicopter artillery soldier and pilot, and the rest of us were cast as guerrillas, including her cousin. She led us around the room on our bellies as if we were crawling through the brush on that hillside while the helicopter swept down on us with machine gun fire.

We stopped the action to check in with Patricia about the next scene when Tim was supposed to shoot her cousin, to inquire if she wanted to proceed with the psychodrama. Her power to decide was reiterated at every crossroads as a way of reinforcing her sense of control over the traumatic memories. She was crying and said she needed to go through with this because she had never had the opportunity to face this part of her personal grief. She directed us to continue on our bellies, told Tim when to fire at her cousin, and instructed Elsa to fall down dead. At this moment, she fully entered her own role and began to cradle her cousin and sob for her, something she was unable to do at the time because she was scrambling through the brush desperately trying to save her own life. The psychodrama afforded a time-out for mourning, which had an additional benefit of social healing because Elsa is a high-ranking member of Group A, and someone that Patricia, as a member of Group B, had been distanced from. And yet she chose her to play the cousin's role, perhaps to addition another layer onto the healing process. When Patricia stopped crying, with no coaching from anyone, she started to rip up the newspapers while cursing the soldiers who killed her cousin and terrorized her people. Central American as well as 'Yanqui' troops were verbal targets of her discharge. We encouraged her to stay with her rage while we witnessed and provided her with a container until she collapsed on the floor exhausted. Moments later she sat up and began to smile and was held by all of us. Lastly, she looked up, saw Tim, and they exchanged a hug for what seemed a long time.

A number of things came up when we processed the psychodrama. First, Patricia expressed amazement at how it felt to enact the scene and have the space to express the range of her feelings, from despair to fury. She said she felt that her cousin and others she had lost were somehow

encouraging her to do this piece of personal work. This acknowledgment alone constituted a milestone. Personal work is often shunned in revolutionary organizations where ideological resolve and unrelenting commitment to the struggle are supposed to absolve the individual of the need to address personal issues.[19] Patricia said she hadn't known how much rage she had inside, although she intuited she had been carrying a vast amount of sadness. She said it felt as if a clearing had taken place between her and Tim, and she no longer feared him. She added that by hugging Tim she felt like something bigger was getting worked out, not just between them as individuals but between our peoples. We all paused and breathed into this possibility.

Second, Tim who was overcome with emotion and tears, shared that around the time when Patricia's cousin was killed, he remembers feeling outrage at the role of the United States in Central America and recalls walking with his two-year old daughter in the woods in the spring of 1982. As an amateur bird-watcher he sighted an unusual bird and looked it up in his guide book only to learn that it winters in Central America and returns to New England in the springtime. He remembers asking himself what scenes of bloodshed this bird had soared above during its trans-hemispheric journey. With this, Patricia's identification of Tim as enemy, and Tim's fear of being branded as such, dissolved as they thanked each other for having taken the risk to expose and repair some of their deepest wounds.

Much was learned from this unexpectedly rich episode. For example, Patricia needed to feel safe and empowered enough not to relegate her flashbacks and anxiety attack into the murky quarters of denial. She also needed to feel caring of self and important enough to name her crisis and come forward in a plea for help. What's more, help had to be available unconditionally and in a timely fashion, namely, late at night. Patricia needed to feel enough trust in the training process as an opportunity for personal healing to come forward. An appropriate method

---

19 This is a personal reflection based on first hand knowledge of revolutionary organizations in Latin America.

of working this through had to be chosen, in this case, psychodrama. The quality of relationship and mutual concern and support among the other three trainees who shared her internship site had to be high enough for them to agree to a change in schedule so all could collaborate with Patricia's healing. The commitment to experiential learning had to be solid enough that all could identify this as a potentially important learning experience for the acquisition of new skills, namely psychodrama. And finally, personal work had to be seen as a possible trampoline for social healing, as in Patricia's sense that what she and Tim did was not for them alone.

4.2.2 The Case of Conflict Between Manuel, Rogelio and Others

Personal animosity seemed to characterize the relationship between Manuel and Rogelio from the very beginning of the program, perhaps even before they arrived in the United States. Manuel, the psychologist and teacher from Group B, had been hired to provide in-country pre-departure training in basic mental health skills for the rest of the participants before they traveled to the U.S. When I visited Central America one month before the training program began in Amherst, I had the opportunity to observe some of the sessions conducted by Manuel, and was surprised at the style of pedagogy used: rote reading from a mental health workers' manual, with frequent requests for repetition of certain passages; mostly large group discussions; limited interactive activities; scarce opportunities for experiential learning. I remember seeing Rogelio on the sidelines during these sessions and do not recall if the tension between him and Manuel dates back to this time. Rogelio was one of the Group A participants with the highest administrative rank in his institution. Based in the capital city rather than the rural zones where most of the other Group A trainees came from, Rogelio had no prior training in physical or mental health and no prospects of engaging directly in the provision of mental health services to villagers. The stated purpose of his selection as a participant in the program was to provide administrative support to the mental health workers upon their return and serve as an advocate for them in the Group A institution. As for

Manuel, upon meeting him and watching him work in Central America, I recorded in my field notes concern for the overlapping of his roles as psychologist, teacher, pre-departure trainer, as well as peer participant in the program. Had I known at the time that he had also been therapist and supervisor to some of the Group B participants, my level of concern would have soared. With so many factors affording him higher social rank than the rest of the trainees from Group B, I was worried that his perceived or real power over others would inhibit their participation in the program.

The issue of social rank among trainees can be challenging in a nonformal education intervention when the intent is to foster an atmosphere favorable to broad participation, acceptance of difference, and the validation of highly disparate levels of knowledge and kinds of experience. Although issues of rank get played out somewhat differently in each training program, for the most part, gender, race, class, education, ethnicity, and institutional affiliation are the key categories that set up rank as a state of mind that governs human interaction and communication.[20] In this particular case, the question of Manuel's rank in the training program was further complicated by his apparent preference for an educational style that imparts information, as opposed to a learning process that draws on people's experience and knowledge, and offers conceptual and technical inputs within that framework.

During my visit to Central America, I tried to level the ground of the playing field among the participants. This seemed important because of the great difference of purpose, work style, and organizational culture of both sponsoring institutions, as well as the more obvious political distance between a hierarchical public institution (Group A) and a private learning institution (Group B). I did this by attempting to make myself equally available to all participants and showing no preference, while acknowledging that the vast need for rural mental health work could welcome a variety of efforts and approaches. At the same time I wanted to appreciate the obvious: as trained psychologists, both Manuel from Group

---

20 This is the working definition of social rank used by Drs. Amy and Arnold Mindell, founders of process-oriented psychology.

B and Elsa from Group A could potentially provide key input to strengthen ITD's ability to deliver an outstanding and highly relevant training program. I did this by having slightly longer interviews with both of them, and asking them to help me better understand the kind of work expected of the trainees upon their return from the U.S., the exigencies of local conditions, and the psychological state of the participants. I told them that I expected the program would benefit from their ongoing insights in the U.S.

When the trainees arrived in the U.S. in mid-March, much to my surprise, Manuel was not among them. I was informed that due to a last minute administrative decision as well as political concerns on the part of his superiors in Group B, Manuel was unable to participate in the program, and had he insisted on coming, he would have jeopardized his job. I recall contacting our Central American colleagues to reiterate that if there was any way to remove the unforeseen obstacles to his participation, he would still be welcome in the program.

Surprisingly, Manuel joined us at the start of week two, which meant that he missed orientation to the program, initial container-building exercises, trust and safety work, group integration and norm-setting, as well as our first moderately successful experience of conflict resolution. At the time, I didn't hypothesize a connection between his absence the first week and the relative ease of the group's integration process and high level of participation. However, once he joined us, the group dynamic and atmosphere shifted noticeably. As I recorded in my field notes, "with Manuel's arrival, the Group B participants defer to him and no longer offer opinions or ask questions as they had during the first week. The atmosphere is almost stifling during week two. Most everyone is walking around on egg shells. It would appear that trainees feel intimidated and suddenly unsure of themselves and insecure about the container we built together during week one."[21] In hindsight I see that with Manuel's arrival, polarity in the group was reconstellated. Whereas, before there had been a variety of opinions among Group B trainees, now

---

21 Field Notes, April 1, 1994.

they seemed to wait for Manuel's pronouncements before rallying in support. To me it felt like considerable backsliding, the unraveling of something delicate yet significant, that had been crafted with great care by all. Little did I realize at the time the opportunity that this represented.

After Manuel joined the program the tension between him, the ITD staff and some of the participants became a seemingly permanent fixture in the group dynamic. The 'Buzón del Pueblo', or People's Mailbox, is a simple support device located in the training room that gives participants the option to anonymously voice concerns or praise in order to bring something to group and staff attention. At the beginning of the program's third week, two notes appeared in the Buzón to the effect that "U.S.A. is completely horrible," and "ITD's pedagogy is inappropriate for us." Both used the same pen and penmanship. As with all notes in the Buzón, these were read to the group. Immediately Juan Pablo, the highest ranking health worker from Group A, stood up to apologize to ITD for such a show of disrespect and said he felt ashamed that someone in the group would voice something so hostile and devoid of gratitude. He stated that whoever had placed these in the Buzón should stand up and publicly offer an apology to the ITD staff. Tension and discomfort filled up the silence in the room.

I spoke and personally thanked Juan Pablo for defending ITD but clarified that personally, I did not feel I required an apology because I wasn't offended. I used this as an opportunity to talk about the role of personal choice in feeling hurt. In this case, all I wanted was greater understanding of the message so I could learn from it, and invited whoever authored the two notes to offer further explanation by way of the Buzón. I explained that I have my own love-hate relationship with the United States, and have no issue with anyone finding it a horrible place, and in fact, given the recent history of relations between the U.S. and Central America, and the presence of people from opposing sides of the armed conflict in the training program, I expected some anti-U.S. feelings in the training room. I spoke briefly about my personal experience as an opponent of the U.S. war in Southeast Asia, and that I could identify with

the feelings behind this message. I added that I would be most interested in knowing what it was they despised about the U.S., and as for ITD's inappropriate pedagogy, I would need to hear more to understand what might need to be adjusted and invited the participants to give us feedback on this issue. What followed was a chorus of voices to the effect that ITD's pedagogy is participatory, encourages the acceptance of differences, supports people to speak, adjusts itself to the many levels of experience and knowledge in the group, is for the most part lively, although some wanted more small group work and icebreakers to help combat the fatigue brought on by so many hours spent in the training room. I thanked everyone who spoke and particularly the person who, by placing these messages in the Buzón, had provoked such an important discussion for all.

In spite of my attempts to turn this incident into an asset many in the group were clearly wounded that one of their members would be, as one of them told me, "so ungrateful." As much as I tried to counter the implied belief that they somehow owed us loyalty because they were in the U.S. on scholarships paid for by U.S. taxpayers, I sensed my arguments were ineffective with those who felt this reflected poorly on the group's image and worthiness in our eyes. I began noticing new ripples in the rift between the Group A and Group B participants. Part of that took the form of renewed tension between Manuel and Rogelio. If one spoke the other countered and challenged. They never chose to work with one another in the small group exercises, and only endured each other when the luck of the draw placed them in the same small group. On several occasions the training design created opportunities for participants to practice feedback techniques in dyads and suggested it would help the whole group if this was done by those who felt discord with one another. Manuel and Rogelio never chose to do these exercises together. The more they practiced avoidance, the more the friction between them mounted, only to be expressed in looks, gestures, and under the breath comments.

Things peaked the last week of the program. We were at that place in the curriculum when our primary focus was on devising a strategy for

in-country application of those skills and techniques deemed most pertinent by the trainees. The condensation of nearly two months of training into action plans was in and of itself a massive undertaking. A review of content, including key concepts, skills, techniques, and approaches was done with the entire group. This review provided the broad outline of the action plans. It was then up to each participant to develop a more detailed plan with others who live and work in close geographic proximity. Faced with such a task, the pseudo-unity of the group seemed to unravel, as the participants decided to design institutionally-based rather than geographically-based action plans. Whatever inroads had been made to coax the two subsets of participants into being one group seemed to get pushed aside as they convened in two institutionally-based units to devise their action plans. When both units came back together to share with one another their intentions, a major altercation occurred. Manuel voiced his opinion that Group A trainees had made a folly out of the training program, would be unable to do much of substance with the acquired skills, and that bringing Rogelio to the United States had been the waste of a scholarship that someone more worthy could have taken advantage of. Rogelio retaliated by accusing Manuel of trying to run the group for his own purposes. At a mere three days from the program's close, we were back where we started from—— animosity, polarity, and mutual accusation as the norm. Whatever spirit of collaboration and group identity we had achieved appeared to have evaporated. In my field notes I wrote that "several participants seem to be holding their breath waiting for this ordeal to end so they can stop pretending they get along with one another."[22] I began to struggle with my own attachment to conflict resolution and realized for the first time that the conflict might not be resolved. I asked myself to uncover why I was so committed to resolution when that didn't appear to be everyone else's priority. I realized that it had much to do with all the unresolved and unprocessed conflicts in which I had taken sides, and all of the resulting pain. I tried to back off, and yet decided to try one last thing.

---

22 Field Notes, May 12, 1994.

Following this blow-up between Manuel and Rogelio I asked Manuel to stay after class for a private meeting. I informed him that as program co-director, I deemed it my responsibility to offer him feedback regarding the impact on the group of his behavior toward Rogelio. I asked his permission to give that feedback, which he granted. I described to him what I saw as group demoralization and gave him my analysis of the group process from their arrival in the United States to this moment, and the multiplicity of factors that have contributed to that process. I made mention of the different offerings that participants had made to one another as they groped toward a shared identity, in part fueled by a desire to overcome assumptions about the less than worthy intentions and agenda of 'the other side.' I suggested that Manuel's branding of Rogelio as a freeloader and potential saboteur gave voice to what most participants had been trying to get beyond, namely, a sense that some were more worthy than others, which is analogous to saying that in Central America some villagers are more deserving of treatment and healing than others, thereby reinforcing the rifts rather than helping to repair them. I told Manuel that I heard in his words to Rogelio both concern and anger that many Central Americans who have risked their lives to bring mental health to those most in need did not get to attend this training, while others whose work is comparably comfortable, unsacrificed, and safe got the benefit of a personal experience that they won't put to use. I told him I acknowledged his anger, and assumed that he is one of the trainees who has risked and sacrificed much to bring healing where the official institutions can't or won't take it. This validation seemed to put Manuel at ease. But I added that whatever Rogelio does with his experience is of potential benefit to all, and his influence within his institution can ultimately support community-based efforts. I also said that by branding Rogelio an opportunist, he ran the risk of retraumatizing the group's wounds and giving a clear message that conflict resolution and reconciliation are not viable in Central America.

At that moment something shifted. In my field notes I deemed it "an atmosphere transformation,"[23] as Manuel suddenly went silent and

---

23 Field Notes, May 13, 1994.

began to sob, saying that it was true, he had been hateful and vengeful. He added that all the hatred and fury he carried inside him were gushing forth now that the program was ending and they were going back home where he didn't even know if he had a job. With no prodding from me, Manuel began to tell the story of his childhood. My role instantly became that of witness and container, as he wove together the threads of a childhood first abandoned by his father, and then his mother. Thereafter Manuel was passed from one relative to another, as he put it, "like an unwanted burden." He ended up begging on the street or working at whatever he could find——whichever proved more apt at guaranteeing his survival. Socialized by prostitutes, Manuel somehow worked his way through high school, went on to college to study psychology, joined the anti-government guerrilla organization, and began to bury his own pain by attending to that of others. He asked my forgiveness for having disrupted the group's integration and wanted to know how to right the wrong toward Rogelio and the rest of the group. I suggested he ask the group.

The next morning, which was the second to last day of the eight week training program, we gathered to place the final touches on the participants' action plans. The session was to begin with an icebreaker and I asked everyone to stand. At that moment Manuel came forward and said he had something to tell the whole group and asked if they would be willing to listen. The group gave its consent and Manuel proceeded to inform the group that he was ready to take responsibility for what he described as his hatefulness and hostility toward many in the group, particularly those from Group A. Manuel said he wasn't trying to make excuses for his behavior but needed them to know something about him other than his membership in the guerrilla organization or his job as a psychologist and teacher. He shared with the group the story of his life, how he was kicked, beaten, ridiculed, threatened, humiliated, abandoned. He said this had hardened his character. The war and the sacrifices he made during it only made things worse. He described loosing his primary mentor, teacher and other close associates during one of the most well-documented and cruel slaughters by government troops. Manuel asked for

the group's help in overcoming his hatefulness and said he didn't want to go back home feeling separate from the rest of the participants. He added that what he most wanted was everyone's understanding and acceptance. Then he addressed Rogelio and Carmina, a health worker from Group A to whom he had been particularly arrogant and condescending. With tears in his eyes, asked their forgiveness. Slowly members of the group, many crying, gathered around to embrace him. There was momentary silence before people began to thank him for bestowing upon them such a great gift. Several participants expressed gratitude to Manuel for taking personal responsibility for his actions and acknowledging to them his own inner struggle. One person said it was a lesson that all could take to heart.

The last person to step toward Manuel was Rogelio, and he did so with hesitation. After some prodding from the group, they gave each other a long embrace and declared their peace. Juan Pablo, the highest ranking participant from Group A, who had also exchanged more than one harsh word and bitter moment with Manuel, said he now realized that his own suffering as a child was not unlike Manuel's. They were more alike than he knew and perhaps knowing that would enable them to work together rather than compete with one another. Manuel thanked everyone for putting up with him and we all took hands and stood in silence for a few moments. Once again it appeared that being able to see self-in-other opened a key gateway toward wrestling with animosity and distrust.

4.2.3 The Case of Alfonsina and the Issue of Family Planning

Alfonsina, a participant from Group B, is very active in her local church and leads prayer groups in her community. She is knowledgeable about medicinal herbs, active in her village's school committee, and works as a dressmaker. Alfonsina has a sixth grade education and recently became affiliated with Group B's mental health worker's training school. Alfonsina was one of the first participants to share personal testimony during the program. Unlike some of the other participants from Group B, she seemed to maintain some degree of distance and autonomy from

Manuel and was vocal in the group about her opposition to contraception, abortion, and sex education for adolescents. Alfonsina blamed homosexuals for the AIDS epidemic. This pitted her in opposition to some of the other Group B trainees who found these positions rigid and reactionary. She also mentioned how her husband used to be an alcoholic, but with help from the local priest, overcame his addiction. Recently they have both begun to counsel other couples in the resolution of marital conflicts and dealing with alcoholism in the family.

Alfonsina was one of two participants who received weekly acupuncture treatments during the training program. She arrived from Central America with blinding headaches, a general feeling of weakness, and frequent anxiety attacks. The treatments were designed to stabilize her mood states, support emotional release and strengthen the flow of "chi" (life energy) in her body.

During the training program the issue of belief system, and its impact on attitudes and behavior was frequently revisited. In several training sessions, participants were asked to examine the components of their own belief systems to determine which thought constructs fueled their actions or reactions to a given issue or event. During one of the training sessions on AIDS education, a young woman named Elvira came to talk with the group. Elegant, seemingly healthy, and articulate, she gave personal testimony about being infected with HIV by her husband, and how her own lack of self-esteem had kept her from questioning him, even though she suspected he was a drug user. In effect, Elvira linked her infection with HIV to gender oppression. Now an AIDS educator, she is dedicated to impressing upon women the urgency of protecting themselves by building self-esteem and personal empowerment. Her message, and the way it was delivered, cut through many assumptions being made by participants about AIDS and who gets it. It had a profound impact on Alfonsina.

The day after Elvira's presentation, Alfonsina stood up and said she needed to address the group. She informed everyone that she had begun

to review the beliefs that upheld some of the arguments she made. Slowly, she was coming to the conclusion that she had been judgmental and intolerant. Alfonsina added that she was rethinking her opposition to sex education for teenagers, the use of contraceptives and her blame of AIDS on homosexuals. She wondered out loud why she had become so rigid and if her daughter's death had played a role in the way she sees life and its challenges. The group received her words with open arms and encouragement. Several members of the group welcomed her thoughts and applauded her courage to publicly question her beliefs.

This incident reveals the useful orchestration of emotional and cognitive interventions. As one of the first participants to share testimony, Alfonsina began her personal healing early on in the program. This opened her to being impacted by someone else's personal testimony, in this case, Elvira. Thus, emotionally she was engaged with the process. Cognitively, the discussion of the link between culture, belief system, attitude, and behavior gave her a map for self-examination. This guided her back into her own inner world in a powerful dialectical loop, which was consolidated by the group's acceptance of her efforts and praise for her honesty. By being acknowledged as a model for others, Alfonsina said her commitment to and trust in her village-based work was strengthened. When asked what allowed her to come forward with this admission, Alfonsina responded that the most important thing for her was that "we are all here to support each other's learning and I can't pretend I'm any different from the rest. I doubted I would be attacked for saying what I said, and I'm glad that the group was so welcoming of my words. That'll make it easier for others to come forward." Once again, safety and container building proved to be critical ingredients in the successful synthesis of educational and therapeutic interventions.

4.3 Case Study Issues and Lessons

In this section the lessons that have been generously offered by the case study are examined. Of primary concern are:

- a differentiation between the tangible and intangible variables in the design and delivery of the eight week training program;
- the question of whether or not therapeutic needs should be addressed in an educational setting;
- the role of educator/therapeutic guides and the participation of para-professionals;
- the nature and characteristics of the healing relationship;
- the role of intra-group conflict in group-based healing.

4.3.1 The Role of Tangible and Intangible Variables

The identification of tangible and intangible variables is helpful for the differentiation of those components of the program that are easily replicable and those that are not. This is not to suggest that the intangible variables cannot be provided for. What it does mean is that the processes whereby they are incorporated into an educational/therapeutic intervention are different.

Included in the tangible variables are: training curriculum, its design and methodology; the combining of 'official' curriculum and extra-curricular activities (e.g., conflict resolution, personal healing, alternative healing practices); the deliberate creation of a safety net in the form of psychological support and back-up for participants; and, the implementation of the training program far away from the site of the armed conflict that the participants witnessed.

On the side of the intangible variables, or what might be called the circumstantial factors, are: personalities of participants and staff; willingness to take risks; dynamics of human interaction; acceptance and acknowledgment of a role for spiritual belief system; and, a commitment to a combination of dialogue, development of shared meaning as means to the building of group identity, working through of conflict, and personal as well as group healing.

It is my belief that it was the combination of these two realms that made this program effective and successful. The degree to which the tangible variables of curriculum and methodology were synchronized with the needs of the participants, and then fused with the circumstantial variables of heightened self-awareness, self-esteem, and belief in and commitment to the group process allowed for a relative ease of movement between the cognitive, emotional, interpersonal, spiritual, social and political threads of this experience.

Among the tangible and intangible factors that merit highlighting are two: (1) the fact that this particular training program took place outside of Central America; (2) my revealing to the group an unwavering commitment to and belief in the psychological and social healing potential of each participant in the context of the group process.

With regard to the first, it is my suspicion that personal willingness to take risks can be amplified by temporarily leaving one's habitual environment where culturally-ingrained behavior patterns, values, and involuntary responses are defined and fostered. With regard to the Central American mental health participants, I suspect that had the training program taken place in their country, considerably more time and care would have been required to create safety, and to cultivate a collective habit of inquiry and attitude of mutual respect. Toward the end of their stay in the United States the participants' risk-taking took the form of a bold questioning of post-war resentments. These resentments feed on belief systems that encourage blame and distrust, while discouraging dialogue and the willingness to discover self-in-other. This questioning helped to foster an interest in self-discovery, self-care, a belief in the role of support, and willingness to offer and ask for it. It also reflected a commitment to model and coach others in order to develop mutual accountability. The aftermath of armed conflict in Central America may make it difficult to engage these competencies.

Second, in terms of my commitment to and belief in the psychological and social healing potential of each participant in the

training effort, I think this was critical to the program's outcome. The participants knew from the outset that I was on the side of their reconciliation and personal healing. As visible frustration with the group's discord became more evident, the participants knew that I was suffering with them. Whereas Western psychiatric approaches suggest neutrality in the therapeutic relationship, I was not a neutral bystander indifferent to the unfolding of the group process. The message I communicated to the trainees was the desire to listen to everyone's opinion, and the belief in the group's ability to work out its differences, if encouraged to do so and given the opportunity. Each time hatred, mistrust or resentment was addressed and transformed into understanding, the group felt validated and affirmed. And every episode of healing, no matter how small, was reflected back to the group as an example of their joint capability, and as grounds for hopefulness. All instances of reconciliation and taking of personal responsibility rather than blaming, were examined, applauded, and used to reinforce the gradual shift in belief system and attitudes among group members.

In spite of the above, there are several problems inherent in the combining of educational and psychosocial healing endeavors. First, it takes a significant time commitment to create reasonably solid foundations for individual and collective healing in the context of a psychoeducational intervention. And this implies the availability of financial support. Second, it requires a willingness on the part of trainees and staff to step into the unpredictable. This translates into flexibility in scheduling and goal-setting. Certain curricular topics and activities may get postponed or left out in order to respond in a timely manner to group conflict or specific healing needs that present themselves. Funders may resist the backing of programs that revise or eliminate some behavioral objectives and expected outcomes. Third, it requires staff that is well-versed in the design and delivery of participatory educational programs, as well as the assessment and treatment of psychological trauma. If staff is adept at the former but not at the latter, in all likelihood, there will not be consensus about how to address the emotional needs of participants. The capability of providing knowledgeable care and an attitude of fearlessness

are required in the presence of the kind of acute emotional pain that presents when working with trauma victims. Fourth, it requires making provisions for the psychological safety and support of participants and trainers alike. This entails a potential expenditure of considerable resources. Trainers need to be assured that culturally-qualified psychotherapists or healers are available and have been briefed about the characteristics of the trainees, nature of the curriculum, intent of the training program, and reality awaiting the trainees at home. Trainers themselves need coaches to help detect signs of vicarious trauma. They need to be part of a support system that includes people not in daily contact with the participants.

4.3.2 Should Therapeutic Needs be Addressed in an Educational Setting?

The Trauma Clinic at the Department of Veterans Affairs in Boston provides a ten-week psychoeducational introduction to trauma before survivors begin therapy. Veterans participating in the program receive information about psychological trauma and the recovery process as a step toward preparation for treatment (Munroe & Bitman, 1994). According to Dr. James Munroe, one of the therapists who designed the psycho-educational program, "we tell people that the psychoeducational program is not therapy so that they don't come in expecting to talk about their traumatic experiences. But for us, the psychoeducational work is part of a therapeutic intervention. When I began doing this work, I would listen to people's stories and the therapist in me would immediately see where this information could lead us. But I would have to remind myself, and them, that this was not the time to go into the material. However, if this had been my sole opportunity to work with someone, I doubt I would stop them from sharing their personal trauma experiences."[24] According to Munroe's experience, the use of psychoeducational settings for therapeutic

---

24 March 19, 1996 interview with Dr. Lisa Fisher, Dr. James Munroe, Dr. Jonathan Shay, Christine Makary, and staff interns of the Outpatient Clinic at the Department of Veterans Affairs, Boston, Massachusetts.

intervention needs to be contextually defined, based on the availability of other options to those seeking healing.

Looked at this way, perhaps the question is not 'should therapeutic needs be addressed in educational settings?', but rather 'under what conditions can this reasonably take place, and what, if any, special provisions need to be made for this undertaking.' Seen in that light, the primary concerns revolve around: existence of a reliable safety net for participants; assurance that participants have control over the choice to heal and the pace of healing; availability of qualified staff that is knowledgeable about and comfortable with educational and therapeutic modalities; existence of a well-integrated staff that works as a team to design and deliver the program, and soften the blow of secondary trauma.

The primary advantage of combined educational and psychosocial healing interventions lies in their potential for individual and group transformation in terms of core beliefs and assumptions, attitudes and behaviors. I would recommend this dual approach for the healing and training of para-professional mental health promoters, if a safe container can be built that allows participants to take personal risks, and if those involved (trainers and participants) commit to the development of shared language and a group identity. Part of this group identity entails peer support and mentoring. It is important that participants be willing to witness each other's pain as a step toward healing, work out differences by fostering an attitude of curiosity about the other, and show a willingness to recognize self-in-other.

The building of a safe container holds many complexities. Can a safe container be built while an armed conflict is going on? Can a physical place be found that is acceptable to all sides in a conflict and that offers necessary guarantees, such as confidentiality, safety, and the absence of interruptions? I tend to deem it unlikely that these conditions can be satisfied during an armed conflict and in geographic proximity to it. Perhaps a safe container could happen during a conflict, if this were to take place physically removed from it; or it could take place after some modicum of peace agreement has been reached, and near the original site

of conflict. But the pressures to perpetuate conflict are very great while violence still engulfs a region or country. No doubt, the delivery of the case study training program in the United States had great advantages for these reasons, although it is important to recognize the disadvantages as well. For example, any intervention taking place at a distance from the site of the conflict is also taking place at a distance from the site of the healing. This means that the approaches, techniques, and strategies may not be applicable to the reality and needs of those who have endured traumatic exposure. It also follows that individual and collective risk-taking, and revision of core beliefs and behaviors may be out of step with what people are truly willing and able to put into practice at home. Personal transformation can be an excruciatingly slow process wrought with considerable ebbs and flows. However, it is important to consider this when measuring and interpreting the outcome of an educational/therapeutic intervention. Participants may feel elated and optimistic upon bringing closure to an experience of individual and group change. However, once they try to think and behave differently in their home environment where people and institutions replicate the dominant patterns, frustration can set in, as well as the immobilizing danger of cynicism. Unfortunately, no longitudinal study exists in this field trial to examine the degree of lasting impact and ripple effect of the intervention.

4.3.3 The Role of Educator/Therapeutic Guides

An important question with regard to the selection and preparation of educator/therapeutic guides is whether prior personal traumatic experiences help them be more effective in their work (see p. 164 for further discussion of this). In my case, previous exposure to psychologically traumatizing events and situations gave me some of what I needed to work with the participants: empathy and compassion; belief in their testimony; trust in the human ability to heal through what at times may appear to be highly intense and even excruciating emotional and physical release processes; and, willingness to do whatever I could to foster an atmosphere conducive to personal and social healing.

As for the complexity and challenge of the combined role of educator/therapeutic guides, I see advantages and disadvantages. Clearly, to follow a group's knowledge-based and experiential learning as well as its emotional process allows educator/therapeutic guides to witness and partake in a potentially profound endeavor. In hindsight, I feel privileged to have played these two roles, while also recognizing the great risk I ran to personal well-being, given their close to unbearable combined weight under the circumstances. I believe that had I created safety and support for myself on the caliber of what I helped create for the participants, it would have been a more sound undertaking.

In any case, as I reflect on this, I tend to see this work as viable if the educator/therapeutic guide is part of a team made up of people with nonformal education and psychotherapeutic training, and a shared commitment to offering participants the option of working with their pain as a gateway toward personal and collective healing. I emphasize the importance of educators having psychotherapeutic training because otherwise fear and distrust of the healing process can overtake them. In my experience, trainers understandably begin to feel as though they are overstepping their boundaries and mandate if they elicit and address the emotional responses of trainees. At the same time, psychotherapists do not necessarily appreciate the importance of placing the individual's suffering in a larger socioeconomic and cultural context, which can best be examined in a nonformal education approach. Also, I underline the importance of creating a team of people with shared commitment to and understanding of the intervention's stated intention of using an educational setting for the healing of psychological trauma. Once emotional floodgates are opened, there is often no chance to turn back.

Based on the field trial study, it is my contention that the part of me that is an educator is enhanced because of my psychotherapeutic training; and the part of me that is a psychotherapist is enriched by my experience as an educator. The place where I have felt frustration in both roles is when I don't know how or am not allowed to bring in the other craft. I have had the experience as an educator of feeling as though my work skims the

surface of what is possible because either I don't feel capable of creating a setting that encourages people to express feelings, or this is culturally or contextually inappropriate. By saying this I am not suggesting that all educational interventions have to anchor in the heart in order to be meaningful. But I am arguing that when dealing with issues that have a clear expression in the heart and spirit (e.g., social injustice, prejudice, gender oppression, domestic violence, social violence, trauma and healing), to examine them exclusively through the filters of the intellect is to weaken their impact.

It is also true, according to my experience, that to address personal issues in a psychotherapeutic setting without reviewing larger considerations of social and cultural context can distort and/or weaken the effectiveness of the intervention. In other words, the role of social forces in the creation of the conditions that lead to psychologically traumatizing experiences, and the role of cultural belief system in shaping how each person interprets the events of their life, need to be examined.

4.3.4 The Nature and Characteristics of the Healing Relationship

The lessons of the case study with regard to the nature of the healing relationship suggest that the fundamental first step in healing was a shift in the relationship to self. This was evidenced by the emphasis participants placed on heightened self-esteem and self-knowing in their ongoing evaluations of the training program.[25] The cultivation of self-care was situated as the cornerstone of the healing relationship.

Participants were encouraged to respond to each other's healing needs, thereby suggesting that peer support is a legitimate avenue of recovery. The role of mentoring and modeling attitudes and behaviors conducive to healing proved to be one of the most important components

---

25 Participant formative evaluations were weekly. Evaluation results were tabulated and fed back into the program for participant and staff discussion. Extensive mid-term and final summative evaluations were conducted. Evaluations combined qualitative and quantitative methods.

of the intervention, particularly in moments of personal testimonial sharing and intra-group conflict.

Rather than therapist neutrality, 'strong' boundaries, and therapeutic distance, the healing relationship between educator/ therapeutic guides and participants was based on notions of solidarity and connection. Educator/therapeutic guides stated their biases and personal experiences with repression and healing. The creation of safety and its continual recasting played an important role in the healing process, as did participant self-regulation. Participants made use of the assortment of healing resources as they saw fit.

The program, including its extra-curricular components, was designed to offer participants a variety of options for healing. Emotional healing was addressed through testimonial sharing in the training room, and in individual psychotherapy sessions with culturally-sensitive psychotherapists. Participants were also encouraged to use journaling for self-healing if this was a comfortable medium for them. Healing the physical body was addressed through massage therapy, lymphatic drainage therapy, sports, and warm-up exercises at the outset of training sessions. The spiritual aspect of the healing process was attended to through group prayer, guided visualization, meditation, and breathwork. Breathwork also supports emotional release through the physical body. Some participants received acupuncture sessions to support them in dealing with the physical symptoms and emotional response they were experiencing. Many participants reported great ease with techniques such as guided visualization and meditation, while some said they fell asleep. No survey was conducted to determine which techniques were more or less helpful to which participants.

4.3.5 The Role of Intra-group Conflict in Group-based Healing

The fact that participants came from such different sponsoring institutions, and that many of them made assessments about each other's political affinity based on allegiance to these institutions, was cause for

concern at the program's outset. However, this aspect of the experience turned into an asset, given the formidable opportunities for group-based reconciliation and healing it provided. For example, the depth of personal work that was required to break through the distrust and hostility among participants was so great that it set a tone that favored change.

Based on the case study I make no abstract generalizations with regard to this highly delicate aspect of the intervention. I can attest that intra-group conflict was ultimately beneficial to the group of participants involved in this case study, but I am not willing to recommend this as a criterion for selection of participants in future educational/therapeutic endeavors. In the case of the Central Americans, the armed conflict had already subsided and the participants were living in a period of precarious peace, but peace nonetheless. Additionally, although a group of participants openly acknowledged affiliation with the anti-government guerrilla organization, none of the other participants took an overtly pro-government or pro-armed forces stance. While this was implied by some participants, there was no one in the training program who wore an army uniform. Had this been the case, the context of the intervention, and no doubt, the outcome, would have been modified. Based on this experience, I would recommend that the fundamental considerations for defining participant profile be based on historical context (pre- or post-war, or wartime), the nature and duration of the conflict, the degree of animosity, the amount of time allotted for the intervention, the amount of support available for participants and staff, the geographic location of the intervention, and the participant selection procedure (self-selection or institutional assignment).

4.4 Conclusions

Much can be learned about the intervention's outcome from the participants' evaluations and final comments. Toward the end of the program, the participants listed numerous techniques and skills as applicable to the Central American context. For example:

- psychodrama

- creation of healing support groups for former combatants
- strategies for interviewing trauma survivors
- play therapy to uncover child sexual abuse
- AIDS prevention through education
- support groups for care-givers
- community meetings to identify problems, analyze options and prioritize intervention strategies
- movement and expressive therapies
- self-esteem building
- design and delivery of educational talks
- organization and facilitation of support groups
- stress management and relaxation

The ITD final evaluation examined key curricular themes: self-care and relaxation techniques; leadership; training of other para-professionals; diagnosis and treatment of community mental health problems; communications and conflict resolution. It also asked participants to rank the degree to which the training program had prepared them to: (1) develop their potential as community mental health workers and change agents; (2) apply preventive mental health strategies and basic intervention techniques; (3) promote participatory diagnosis of community mental health problems; (4) create peer teams and support groups for mental health workers and community members; (5) design and deliver educational talks to strengthen the emotional health of their communities; (6) enhance their role as community leaders to motivate the community around mental health issues; (7) apply healthy communication skills and contribute to conflict resolution; (8) train others in their community and institution or organization. [26]

---

26 Results for question # 1 revealed 46% ranked it good, while 54% ranked it excellent; for question # 2,results indicated that 4% ranked it acceptable, 42% ranked it good, and 54% ranked it excellent; for question # 3, 4% ranked it acceptable, 33% ranked it good, and 63% ranked it excellent; for question # 4, 4% ranked it acceptable, 29% ranked it good, and 67% ranked it excellent; for question # 5, 13% ranked it acceptable, and 54% ranked it excellent; for question # 6, 4% ranked it acceptable, while 48% ranked it good and 48% ranked it excellent; for question # 7, 43% ranked it good and 57% ranked it excellent; for question # 8, 9% ranked it acceptable, 59% ranked it good, and 32% ranked it excellent.

Participants deemed the training program a success from several standpoints. They highlighted:

- greater understanding of relevant community mental health concepts;
- acquisition of applicable mental health skills for diagnosis and treatment;
- learning how to conduct participatory needs assessment and help in the design of a nonformal education training;
- deepened understanding of how to form work teams, peer support groups, and to be mentors;
- personal growth with an emphasis on heightened self-esteem, self-knowing, and self-care;
- massage and other alternative stress reduction and healing techniques;
- enhanced leadership abilities and communication skills;
- greater understanding of the interface between social context and personal problems;
- greater understanding of issues such as psychological trauma, domestic violence, and child sexual abuse;
- hands-on conflict resolution experience;
- hands-on personal healing experience.

Based on the quality of information that the evaluation results reveal, a number of improvements could be made to the evaluation design, most notably a greater articulation between quantitative and qualitative methods. For example, eighty per cent of participants deemed the level of training sessions 'excellent,' while twenty percent thought it was 'good.' This kind of data provides no indication of whether those who thought the level was good wish that the training sessions had been more demanding, or less demanding.

Several processes occurred during the program that seemed to play an important role in its outcome:

- creation of atmosphere of safety and trust, the bonding of participants to one another in a sense of common purpose, and the creation of a safe container to hold pain and suffering;

- application of exercises, introduction of concepts, and modeling of attitudes that encourage openness, flexibility, curiosity about conflict and difference of opinion, rather than rejection or intolerance;
- use of metaskills that model trust, respect, honesty, humbleness, vulnerability, openness, and taking of personal responsibility, that allow others to come forward in a spirit of healing and reconciliation;
- "change moments" and substantial shifts in group atmosphere;
- recognition of self-in-other;
- holding of conflict and disagreement in the context of the interconnectedness of all things.

At times during the training program, it felt as though there was no precise or succinct language to describe the above. This brings up a compelling point for reflection: when engaged in something as complex as this kind of intervention, to come upon twists in the road and have no obvious tool for naming them simply augments the already dizzying effects of the experience. It is my hope that the recounting of this intervention serves as a signpost for others.

The training model that carried this complex process wove together the realms of the cognitive, behavioral, spiritual, social, political, emotional, relational, and physical body. The glue that made it stick was safety and trust and the fostering of self-awareness and self-care as the necessary points of departure for working with others in a helping capacity. The process was nourished by the deliberate introduction of a multiplicity of skills, concepts, exercises and interventions that touched and spoke to each individual differently. The primary container for the entire endeavor was shaped by what appeared to be a shared spiritual belief system on the part of the trainees, and their willingness to express this and dedicate their efforts to concerns that transcend and yet include their individual lives. For this kind of approach to be applicable elsewhere, the competencies of the mind, as well as the heart and the spirit have to be cared for and believed in.

PART 3
CONCLUSIONS

INTRODUCTION

In Part 3 the different threads of the dissertation are brought together. Chapter 5 explores the intersection of findings from the literature review and the case study on the viability of combined educational and psychotherapeutic interventions. In Chapter 6, guidelines for psychosocial educational interventions and the preparation of educator/therapeutic teams are presented. The needs for future inquiry, such as the role of intra-group conflict in group-based healing, and the role of para-professionals, are outlined.

CHAPTER 5
FINDINGS ON THE NATURE OF TRAUMA AND THE VIABILITY OF EDUCATIONAL/THERAPEUTIC INTERVENTIONS

5.1 Introduction

Many issues raised by the case study are supported by findings reported in the literature. These intersections constitute a common ground which underlies some of the essential features of psychosocial educational interventions. Covering different levels and facets of the educational/therapeutic experience, these features can be grouped into four general categories:

- an integrative approach to healing;
- the role of larger context in the healing process with trauma victims;
- the nature of the therapeutic relationship with trauma victims;
- the inner workings of psychosocial educational interventions.

5.2 Essential Features of Psychosocial Educational Interventions

5.2.1 An Integrative Approach to Healing

Several sources in the literature speak to the importance of considering the whole person when attempting to respond to the needs of trauma victims (Herbst, 1992; Gonsalves et al., 1993). Some authors have elaborated on this theme, as with Merwin-Smith's (1987) wholistic approach, Harvey's (1996) ecological model, and Wilson's (1989) person-environment model with its emphasis on mind/body responses. Other authors, while not focusing on the conceptualization of models or approaches, implicitly endorse an integrative approach by considering the emotional, physical, spiritual, and social needs of trauma victims as fundamental for recovery (Solomon et al., 1992).

Findings from the case study indicate that successful outcome of the intervention was determined in part by the ability to respond to the multiplicity of needs manifested by the participants. These needs were

spread across a wide spectrum: physical, psychological, emotional, cultural, social, spiritual, culinary, recreational, medical, language. Some of the participants arrived from Central America with physical ailments. Others seemed to somatize their psychological trauma, causing them great physical or emotional discomfort as particular curricular themes reminded them of unresolved personal problems. Evidenced by sobbing, complaints of dizziness, severe headaches, body pains, or shortness of breath, sometimes this signaled a need to temporarily shift from the official curriculum to activities such as massage, meditation, warm-up exercises, sports, or a simple time-out. At these moments, I would request the group's permission to refocus our attention, and request the individual's permission to offer them support. On occasion the provision of support would take the form of an intervention during the training session. Gradually, the participants began to provide different forms of support to each other.

In some cases, participants required additional help to relieve physical symptoms (acupuncture, medical treatment). According to verbal comments from participants and their evaluation results, the training program's readiness and capacity to respond to these needs deepened the participants' feelings of safety.

During the course of the intervention, the trainees spoke of the importance of spiritual healing and reconciliation among themselves. Often training sessions would begin with prayer circles or the singing of a song. This happened either at the request of the participants or because staff intuited the need. Some of these occasions were prompted by feelings of emotional vulnerability due to challenging group dynamics, or the aftereffects of sharing personal testimony; some were due to sad news from home or acute feelings of home-sickness.

5.2.2 The Role of the Larger Context in the Healing Process

Many sources in the literature make reference to the importance of survivor awareness of the overriding social issues and forces that are

behind the violence and brutality they have experienced (Martín-Baró, 1982, 1988, 1994; Freire, 1972, 1973; Freire & Macedo, 1995; Vidal, 1990; Rojas, 1990; Lykes, 1993, 1994; Korin, 1994; Aron, 1992). As knowledge replaces the isolation and self-blame that generally feed on psychological trauma, personal problems can be cast in a larger context. This contributes to healing and induces a collectivization of individual pain and its processing. According to Rhea Almeida of the Institute for Family Services, "we emphasize to clients that the problem is not theirs, it's all of ours. Everyone's humanity is limited when violence is perpetrated. And this message supports everyone's healing. We take the personal problem and thread it into the larger picture, and this relieves individual guilt while making people more accountable to themselves and one another."[27]

Problem-analysis approaches in education can be a tool for placing the personal in the larger context of social determinants (Freire, 1973; Korin, 1994). Problem-analysis identifies the 'why' and 'how' of things, and when done in a participatory educational setting, can add to the process of depersonalization of individual problems.

The experiences of the case study were very telling with regard to the significance of situating personal pain and suffering in a larger framework. This was addressed at the outset of the intervention when participants were asked to brainstorm a two column 'T-chart' to identify the most prevalent mental health problems in their communities, and those social factors contributing to the creation of these problems.

The training segment on conflict resolution also relied heavily on the larger context issues regarding the evolution of the human species, the role of conflict, and effective techniques for conflict management and resolution. The group examined and discussed several case studies of conflict resolution, including the different Central American approaches to conflict and its resolution. Likewise, the presentation of theory about resistance or openness to change, and group dynamics, seemed to set the

---

27 Interview was conducted on May 11, 1996.

participants at ease with regard to their normalcy as a group, and the predictability of certain aspects of their internal process.

A general discussion about the role of war, poverty, social violence, and gender discrimination was used to frame the topic of psychological trauma. When this topic was introduced, the group's relief was noticeable through the kinds of questions asked and comments offered. This was most obvious when the symptomology of posttraumatic stress disorder was described. Several participants mentioned feeling at ease as they heard their own private symptoms portrayed in a general description. They expressed amazement to learn that their suffering had explanation. Something similar happened when the topic of child sexual abuse was covered in the curriculum, although in this case, participants tended to share their feelings of relief more privately.

5.2.3 The Therapeutic Relationship

A number of researchers and practitioners make reference to the uniqueness of the therapeutic relationship with trauma survivors. There are numerous instances in the literature that make reference to the ways in which therapeutic work with trauma survivors unsettles some of the pillars of psychotherapy as it has been known. Among these are therapist neutrality, therapeutic distance, boundaries, confidentiality, and the role of para-professionals in the recovery process (Greenspan, 1995; Sykes Wylie, 1996; Catherall & Lane, 1992; Roth & Batson, 1993; Ofri, Solomon, & Dasberg, 1995). The fundamental argument underlying these challenges to some of psychotherapy's long-standing assumptions is that trauma victims need reliable, trustworthy human connection in order to heal with a therapist, and that they need to know where the therapist stands with regard to the people or circumstances that induced their psychological trauma. In addition, some trauma victims become survivors and heal without the assistance of trained practitioners (Herman, 1992a). The role of mentors, peers, coaches and the ability of the victim's community to provide support, safety, and understanding can obviate clinical intervention.

As for the case study, during my pre-departure visit to Central America, upon meeting the participants for the first time, I gave them a synopsis of my personal history with regard to the topics and concerns of the training program. I informed them of my personal experiences with political repression, military dictatorships, disappeared loved ones, and personal loss. I explained that I was sharing this information so they would know where I stood with regard to the curricular content of the program. Likewise, during the course of the training program, I shared personal testimony when I deemed that it would illustrate points relevant to the curricular material, or model a behavior that was pertinent to the personal or collective healing process.

Although one of the primary support structures available to participants was individual work with psychotherapists, some participants wanted to share their personal experiences with me before revealing them in their therapy sessions. Participants not working with therapists also requested time to discuss personal problems with me as concerns surfaced in the course of the program. To the best of my ability, I responded to these requests, knowing full well that I was breaking two of the golden rules of therapy: boundaries and distance. My boundaries were admittedly lax, and the distance between me and the participants was short. On occasion (for example, during our two-week stay in Boston), I provided crisis intervention as the need arose. No doubt, part of my own exhaustion during the case study can be attributed to the degree of my availability to participants, and I am aware that by doing so, I was also modeling for them that educator/therapeutic guides get exhausted rather than replenished from their work. This could have been avoided, had I created a strong container for myself. However, in spite of its perils, I believe the role proved to be a significant factor in the sustenance of participant feelings of safety during the more trying moments of the healing experience.

As I reflect back on my failure to exercise adequate self-care during the case study intervention, and the considerable personal price paid for this lacking, I find myself asking what stopped me from engaging in this

process in a more balanced manner. A number of factors seem to have contributed to this situation:
(1) at the time of the intervention, I did not fully appreciate or understand the dangers of secondary traumatization;
(2) I underestimated the amount of time and effort that would be required in order to properly address the psychological and social healing needs of the trainees;
(3) rather than feel comfortable admitting to the participants my limitations as their witness and support, I chose to endure the situation and postpone my own needs for a time-out;
(4) the degree to which I supported participant healing (individual and group) was self-imposed and increased as their trust in the process and willingness to share their stories grew; no contingency plan existed for the provision of additional human resource support, either to the trainees or to me;
(5) I suspect that political considerations played a role in my decision to make all possible resources for healing available to the participants, given the role of the U.S. in the orchestration and funding of one side in the civil war that engulfed the participants' country. As a citizen of the U.S., I feel accountable to those whose lives have been damaged by the harmful impact of U.S. foreign policy. Committing myself to making their U.S. training experience also a pathway for healing was part of trying to make reparations for that wrong.

Were I to have the opportunity to replicate or adapt this intervention, there are several things I would do differently with regard to self-care. First and foremost, I would share with the participants my own process of self-knowing with regard to my limitations and needs for support in order to better serve them as an educator and therapeutic guide. One way to do this would be to ask them for support when I am no longer able to give it to myself or am no longer capable of witnessing their pain and suffering without triggering my own wounds. By caring for myself in their presence and allowing them to participate in that process, I would model for them a behavior that they will most likely need to demonstrate in their communities. Second, I would create a personal support group to

help me manage secondary traumatization and more ably recognize my limitations. Third, I would create contingency support for crisis intervention. In the following chapter, self-care guidelines for educator/therapeutic guides are offered (see p. 163).

5.2.4 Inner Workings of Psychosocial Educational Interventions

A number of factors fall under the general category of what can be called the inner workings of psychosocial educational interventions. These are safety and container-building; self-care; peer support, mentors, mutual support groups; community-building and connection; and team-building and integration of staff.

In the literature, authors with professional experience in varied geographic, cultural, and social settings concur as to the importance of creating and sustaining an atmosphere of safety for recovery and healing of trauma victims (Esterio, San Ramón, & Almarza, 1990; Morera & Taboada, 1985; Jareg, 1995a; Rojas, 1990; Herman, 1992a; Bass & Davis, 1988). Markova (1994) refers to container-building as the process whereby a group comes together to foster a supportive and safe emotional and social space that can literally contain emotional release, risk-taking, and the challenging of long-held assumptions and beliefs.

In the case study, safety and container-building were seen as a never-ending process. Topics were introduced, techniques were presented, and healing activities were offered if they added to the safety and strengthening of the human container. Safety and container-building comprise a significant section of the bottom line of the intervention. And yet, they cannot be reduced to a series of exercises, icebreakers, or theoretical conversations. Rather, safety and container-building reflect an attitudinal state that governed the intervention and its decision-making procedures.

There is scarce mention in the literature of self-care for members of victimized groups and those working with them (exceptions are Baron, 1994; Munroe, 1993). Most of the references are to the dangers of secondary trauma or vicarious trauma (Munroe et al., 1995; Stamm, 1996; McCann & Pearlman, 1990). However, I found no explicit references to the teaching of self-care to para-professionals who have been exposed to many of the same horrifying experiences as the community members they purport to serve. In this regard, I believe that the results of the case study are a contribution to the field.

The issue of self-care was visited and revisited as a cornerstone of the case study. Initially, it was discussed as theory. While everyone has unresolved issues and pain, this exists more so for those who have been exposed to traumatic experiences. Under 'normal' circumstances, people have the choice of avoiding these issues, or coping with them by examining and processing their impact. If para-professional mental health workers choose the route of avoidance and perhaps denial, they run the risk of considerable suffering each time someone else's testimony reminds them of their painful past. How can caregivers serve others if they haven't tried to address their own unresolved grief? A role play illustrated this point and the participants had the opportunity to examine their own trigger mechanisms on many occasions.

The theory and practice of self-care was also presented as a component of a healing strategy based on peer support, mentoring, and modeling. In the literature, Aron (1992), Sykes Wylie (1996), and Solomon et al. (1992) identify the latter as pillars of a recovery approach that prioritizes community-building and the creation of a standard of collective accountability by fostering mutual aid and support. The case study built this into its very design and methodology. Participants worked in small groups and were encouraged to identify in themselves and each other behaviors that provided mentoring to the whole group. Feedback mechanisms (face-to-face and anonymous) were used frequently in order to reinforce and appreciate attitudes that favored intra-group understanding and healing. The action plans formulated by participants

toward the end of the program were conceived of and designed with self-care as their backbone. Participants were cautioned against attempting to create and facilitate mutual support groups for community members if they themselves were not exercising self-care and did not belong to a peer support group with other former trainees. Recent correspondence with members of the group indicate they have monthly meetings to discuss their work and support each other's efforts to provide community mental health services while exercising self-care.

In all these discussions, general guidelines about the meaning of self-care were offered, but each participant was encouraged to provide their own definition. These guidelines defined self-care as self-esteem put into action. In other words, the genuine valuing of self leads to consistent caring for self, in whatever form this takes. For some, it might mean not always putting themselves last. For others, it might take the form of deepened self-knowing and awareness. There was considerable discussion in the group about cultivating an attitude of self-care and sharing this with spouses and children so as to stop the cycle of self-effacement that makes it easier for some to have power over others.

There are two primary problems that can threaten the application of a healing approach that situates self-care as its centerpiece:

- 1) when para-professionals are part of an institution that emphasizes a quantitative measurement of success, they may not be afforded the time, resources, and support to exercise self-care, strengthen self-esteem, and participate in peer support groups or mentoring circles with their fellow para-professionals;

- 2) when psychosocial educational interventions introduce self-care where there has been none either because people have been focused on survival or were socialized to believe that self-care equals indulgence, the systematic practice of self-care may be a hard personal and collective change to make.

Given the above, while the findings of the case study and sources in the literature indicate its importance, the fostering of self-care among para-professionals requires considerable attention, and may be one of the most difficult and challenging of tasks.

Self-care also needs to be permanently demonstrated by educator/therapeutic guides or anyone else who, by virtue of standing before a group of people, may become their role model. This reinforces the need for significant team preparation and building. In the case of the Koach project (Solomon et al., 1992), staff therapists and coaches were prepared during a two-year interval for a month-long psychoeducational intervention. The study with the Central American mental health workers reveals the strategic importance of shared vision and purpose among staff. Only on that foundation can there be a coordinated response to participant needs, and willingness to strengthen the container that allows participants to learn while, at the same time, working on their individual and social healing.

CHAPTER 6
GUIDELINES AND NEEDS FOR FUTURE RESEARCH

This final chapter of the dissertation offers general guidelines to practitioners and victimized groups for specific facets of the design and delivery of educational/therapeutic interventions. Concretely, the self-care of educator/therapeutic guides, and the training required for educator/therapeutic guides are explored. It also suggests areas for future inquiry that would significantly enhance the understanding of programs that rely on a combined psychosocial and educational approach for scholars, practitioners, and victimized groups. The chapter ends with final considerations on the possibilities of healing in the face of hatred and intractability.

6.1 Guidelines

- Self-care of educator/therapeutic guides:

  1) Identify how you as an educator have worked through your own history of psychological trauma.

  2) Identify your own unresolved psychological issues and commit to working on them, particularly while serving as educator/therapeutic guide.

  3) Conduct a personal inventory about self-care: what it means to you, how you exercise it in your life, what gets in the way of self-care.

  4) Be part of a team of educator/therapeutic guides who openly share with one another insights into their strengths, weaknesses, work habits, unresolved issues, possible triggers, personal definitions of self-care, and personal self-care habits. Make explicit agreements with one another regarding self-care.

  5) Discuss among educator/therapeutic guides the dangers of secondary trauma, identify its common features, and reach explicit agreements about what to do if team members exhibit symptoms of secondary trauma; have each team member share how, based on self-knowledge and past experience, they presume they will acquire and exhibit

secondary trauma; discuss the meaning of burn-out in the larger social and cultural context.
6) Organize support for educator/therapeutic guides from people outside of their teams who are aware of the nature of their work and the risks it entails, and commit themselves to serving as a safe container for educator/therapeutic guides during interventions.
7) Include time for self-care in the team's weekly work schedule for each educator/therapeutic guide and be rigorous about honoring this allotted time; self-care activities include, among other things, rest, sleep, massage, acupuncture, journaling, sports, exercise, solitary time, reading.
8) Discuss among educator/therapeutic guides the meaning of rank and privilege and how this might influence the team's ability to integrate and each member's self-care habits.
9) Acknowledge differences among team members (social, political, religious, cultural, gender), and confront the feelings and anxieties this may bring, rather than focusing on those differences.

- Training required for educator/therapeutic guides:
Educator/therapeutic guides need several bodies of knowledge and experience to draw from in order to be effective in their work. These can be grouped into three categories: personal knowledge and experience, educational knowledge and experience, psychotherapeutic knowledge and experience.

1) personal knowledge and experience: there is a degree of self-knowing that is beneficial to the kind of work involved in psychosocial educational interventions. Self-knowing makes it easier for educator/therapeutic guides to monitor their own responses to the pain and fear carried by participants in these interventions. Self-monitoring increases the educator/therapeutic guide's ability to separate personal issues from those of others. It also reveals to each educator/therapeutic guide their personal strengths and weaknesses as team players, and thereby allows them to share this information with the rest of the team.

Personal experiences that have either allowed educator/therapeutic guides to confront their own beliefs about and responses to violence, or exposed them directly to it, are seen as beneficial insofar as they help educator/therapeutic guides to better understand participants, and facilitate the kind of self-disclosure that might help participants to better trust educator/therapeutic guides. It is important that educator/therapeutic guides have considerable knowledge of and/or personal experience with political repression, detention, torture, disappearance, terror, refugeedom, combat experience, and forced exile. It is also helpful if they feel personally capable of serving as mentors and models for others with regard to healthy emotional responses to violence, conflict, and life challenges. Having a spiritual belief system, or being respectful of those who do, is essential in this work.

2) educational knowledge and experience: includes the ability to conceptualize, design, prepare, and deliver participatory nonformal education programs. This implies possession of a solid grasp of nonformal education theory, methodology, techniques, skills, and activities. Particular emphasis should be placed on those skills and techniques that introduce larger context issues into group discussions (e.g., problem analysis tools, such as community mapping, problem trees, 'why' chains). It is also important that educator/therapeutic guides know how to draw from a group of participants their own knowledge and interpretation of a given topic. They need to know the difference between education and facilitation, and inform a group when they are doing one or the other. In addition, educator/ therapeutic guides need to feel comfortable with the inevitable changes in design, fluctuations in and unpredictability of group dynamics, and shifts in participant needs and interests. Given the nature of the work of educator/therapeutic guides with victimized groups, they also require familiarity with conflict resolution theory, models, and applications. Some knowledge of and experience with the dialogue method and process-work are strongly recommended. Educator/ therapeutic guides need to feel comfortable in small and large group

environments and may require the skill (meta and technical) to train others how to create and run peer support groups.
3) psychotherapeutic knowledge and experience: includes the nature of psychological trauma; its different developmental impact on children, adolescents and adults; the impact of traumatization on specific groups, such as women, ethnic groups; cultural variations in diagnosis and treatment; and, healing strategies that are known to be effective at the community level. Educator/therapeutic guides need to know that trauma evokes different human responses (emotional, cognitive, behavioral, physiological, and social), and be familiar with a broad range of treatment approaches and techniques, including crisis intervention. It is important that they have prior experience in healing relationships, both as clients and helpers, and understand why the long-held tenets of the therapy relationship are of questionable applicability to trauma survivors. They require familiarity with and openness to healing techniques that work with the human body as well as the emotional world of the victim, and need to feel comfortable working with group-based healing.

6.2 Needs for Future Inquiry

Future studies would benefit by incorporating a follow-up phase into the research design. If self-knowing and self-care are pivotal indicators of the success of psychosocial educational interventions, meaningful examination of these factors can only take place over time, and once participants are reengaged with their families, communities, and institutions.

There are a number of the working hypotheses that emerge from the literature and/or case study that require further inquiry. Those that have been readily identified are:

- Role of intra-group conflict in group integration and healing.
  Based on the findings of the case study, an appropriate conclusion is that the level and nature of intra-group conflict, and how this was

understood and handled, ultimately contributed to personal and social healing of the participants. As stated, two years after the finalization of their U.S.-based training program, the Central American mental health workers continue to meet as a group on a monthly basis to support each other's self-care and community-based mental health endeavors. To the best of my knowledge, these self-regulated and self-facilitated gatherings include former trainees from both Group A and B. This makes the mental health worker's training program one of the most successful and outstanding of its kind, in terms of lasting, group-motivated follow-up activities. [28] It is believed that this can be attributed, at least in part, to the depth of group integration achieved after working through significant intra-group conflict. However, there are no systematic studies that examine factors contributing to ongoing follow-up, or its lack, with other comparable training program participants. For this reason, it would be unwise at this time to make generalizations about the role of intra-group conflict in group integration and healing. However, the working hypotheses of the case study allow us to infer that the following factors played a role in the favorable outcome: 1) the training program occurred in a post-war period; 2) no one in the group wore a military uniform; 3) no one in the group positioned themself as staunchly pro-government or pro-army; 4) the training program took place geographically far from the place of conflict; 5) participants wanted to be identified as caregivers, helpers, and healers in their communities; 6) participants understood that in order to do the former, they had to learn about and experience reconciliation and healing among themselves. A shift in any of these factors might influence how educational and therapeutic strategies would be applied to achieve the desired outcome. Research into the impact of educational/therapeutic interventions in settings other than the one analyzed in the case study would make a significant contribution to the field.

---

28 Based on personal correspondence with participants and conversations with key Central American staff who supervised the participant selection process for the mental health workers training program.

- Role of para-professionals in healing at the community level and its impact on same-culture interventions. The very conceptualization of the training program that provided the basis for the case study raises a question about the degree to which professional mental health care providers can effectively and appropriately attend to the healing needs of victimized groups. The RFP that provided the background to the training program mentioned that the armed conflict created a nation of people in desperate need of mental health services, while it simultaneously weakened the infrastructure necessary to provide these resources. It added that a disproportionate number of individuals requiring mental health services live in the remote former war zones of the country, which are also among the most poverty-ridden regions of the country. The bulk of the country's professional psychotherapists live and practice in the capital city, and are not trained or inclined to provide community mental health assistance to the rural population. The results of the case study raise another question: even if the professional psychotherapists were willing to provide services to the rural war-torn civilian population, would their methods and approaches be the most appropriate and effective? And what's more, would the social and cultural differences between them and the rural poor diminish the impact of their efforts? By raising this question, I am not suggesting that helpers must necessarily have the same social and cultural background as those they are attempting to help, but that under the circumstances of massive psychological trauma in the aftermath of armed conflict, community-based para-professionals may be more able to create safe containers, organize peer support groups, encourage testimonial sharing, and introduce some of the larger context issues that inform war and violence in an educational and healing setting.

A working hypotheses of the case study is that how para-professionals and professionals identify their particular contributions to the healing process and devise ways to work together is more important than which group has more to contribute.

No studies were found that examine the collaborative roles of para-professionals and professionals in a comprehensive community mental health program. There is a need for research to help sort out the specificities of each group's role, and how to prepare and train both groups to work collaboratively with one another.

- The impact of culture on psychological traumatization and healing. As indicated by research in cross-cultural psychiatry and the ecological view of psychological trauma, people attach different meaning to events in their lives depending on the cultural frames that have socialized them, the ways their families and communities respond to traumatic exposure, and their degree of connection to their cultural identity. The field would profit from research into the development of culturally-appropriate diagnostic and treatment approaches, and context-bound definitions of illness, trauma, and healing. There is an additional need for research that focuses on the social, economic, and cultural components of recovery from traumatization. The rebuilding of social and economic networks might be an important indicator of psychosocial healing, and yet this is barely addressed in the literature. There is also little mention in the literature of studies that examine culturally-derived coping patterns. There is a need for further study of traditional coping patterns and whether these have been disrupted by armed conflict. There is much to be learned from individuals who, while having been exposed to potentially traumatizing situations, do not become psychological casualties.

- Whether prior personal traumatic experiences help educator/therapeutic guides do their work more effectively. Both the literature and case study allude to the usefulness of prior personal traumatic exposure for caregivers working with victimized groups. The usefulness is three-fold: 1) caregivers are more likely to believe victims when they themselves have experienced flashbacks, intrusive memory, withdrawal, and other common sequelae of traumatic exposure; 2) caregivers are less likely to be afraid of victims' stories and symptomology; 3) victims are more likely to trust the healing

relationship with someone whose personal self-disclosure reveals comparable experiences and successful healing. However, no studies were found that discuss the degree to which it is important to intentionally recruit caregivers who have suffered and healed from psychological trauma, and the extent to which this may impact favorably on healing outcomes with victimized groups. If the intentional recruitment of previously traumatized caregivers is to become a working hypotheses that informs the preparation and design of psychosocial healing interventions, there is a need for further research to substantiate this.

- Importance of context: is the heritage of nonformal education a necessary pre-condition for developing an educational/therapeutic intervention? The case study offers no conclusive evidence of the degree to which the success of educational/therapeutic interventions depends on participant familiarity with nonformal education methodology. As pointed out in Chapter 4, the teaching methodology used during the in-country training that participants received before traveling to the U.S. was not in the tradition of nonformal education. This might indicate that nonformal education is less widespread among mental health workers in this particular Central American country than in other Latin American countries. And yet some of the participants, although not all, were familiar with participatory educational techniques such as icebreakers and brainstorm exercises. Thus, it might be safe to infer that nonformal education, though known in their country, had not been directly experienced by the majority of the participants. And yet it was effective. A hypotheses that requires further testing is that the application of participatory nonformal education methodologies and techniques do not need to circumscribe themselves to those who are already familiar with them.

Some of the above-mentioned questions that require additional research could be addressed in a multi-year study of the Central American mental health workers. How do the former trainees explain their monthly meetings? Are the meetings an indicator of the success and

effectiveness of their U.S.-based training program? What aspects of their training experience have proved most useful, and least useful, and why? What personal changes in belief system or behaviors have been lasting? Which have been the most difficult, or the least difficult to modify, and why? How do they assess their own self-care habits? Have they had any success in spreading the notion and practice of self-care? How have they aided one another in addressing new conflicts that have arisen? How have their personal changes impacted on family members and neighbors? Has their level of empathy and ability to suffer with others changed? If so, what would they attribute this to? Have they had impact in their institutions? If so, what kind of impact? If not, what have been the primary obstacles? Have they been able to form peer support groups? If so, why? What difficulties have arisen? How have they approached these difficulties? Do they want additional training? If so, why? In what areas? These are some preliminary research questions that could be posed in a follow-up study with the Central American mental health workers.

One of the working hypotheses of this dissertation affirms that cultural relevancy is critical to the effective treatment of psychological trauma. This finding would be better understood with an international comparative analysis of psychological trauma in culturally-different war-torn regions of the world. A qualitative research study with, for example, people from Bosnia, Rwanda, Israel, and Tibet might reveal information that would greatly enhance the creation of educational/therapeutic curriculum and implementation strategies. Different understandings of trauma, coping strategies, treatment approaches, and healing interventions would benefit the international community of victimized groups, practitioners, and scholars by contributing to the existing storehouse of knowledge.

6.3 Final Considerations

It is my hope that this study contributes to the discussion among practitioners, victimized groups and survivors about how to approach the daunting task of healing the psychological, spiritual, physical, and social

wounds of war and violence. I am convinced that this can only happen in the protective grasp of community, whether that be geographically, culturally, or relationship-based.

As I reflect back on the case study, I cannot help but pose the following question: what would be the forms and features of a psychosocial educational intervention if I were to design it unencumbered by contractual obligations, time constraints, and preestablished curriculum requirements?

The first key feature of such an intervention has to do with the composition of the staff and the staff-participant ratio. As educator/therapeutic guides, staff members would be well-versed in nonformal education as well as psychosocial healing with victimized groups. They would have previous personal exposure to psychological traumatization, or considerable knowledge of it and professional experience working with survivors. There would be one staff person for every four participants.

Second, individual and group strengths and needs assessments would be conducted. Individual and culturally-based coping strategies would be identified.

Third, each participant would be given guidelines to reflect on and determine broad personal goals prior to the intervention.

Fourth, several staff members would have the opportunity to visit the participants in their communities prior to the intervention. Emphasis would be placed on understanding their present and/or future roles as mental health workers, and community expectations of them upon their return from the training.

Fifth, depending on the characteristics of the participants and the nature of the armed conflict they were exposed to, I would introduce early on a constructive remedial action (e.g., building part of their training site). This would be more important were the intervention to occur during or

soon after the armed conflict, were the level of hostility very high, and/or were the participants extremely distrustful of one another.

Sixth, the intervention would be structured according to key personal learnings, as well as curricular topics and themes. For example, mechanisms would be established so that participants could track their own process of self-awareness, the interaction between cultural and personal belief system, and their attitudes and behaviors. Emphasis would be placed on establishing peer support groups among participants during the intervention, with an eye to their continuity once participants return to their country.

The experiences of the case study have left me optimistic about humanity's willingness and abilities to heal its collective heart. In spite of the difficulty of my role as educator/therapeutic guide and participant observer, the training program was for me an ultimately empowering and life-affirming undertaking.

Obviously, the larger implications of this work go beyond the realm of psychological trauma. The issues raised in this study can also apply to the kind of social change work that intentionally challenges individuals to become what the dominant culture tries to prevent them from being. It is in this place, where the personal and social stand face to face, that educational/therapeutic interventions can flourish.

As I reflect back on the strongest features of this process and the learnings it has implanted in me, I find myself believing that without hate, there can be no reconciliation, and without suffering there can be no healing. Some in the world would like to wave a magic wand and extinguish the many faces of anguish and hatred; others advocate getting on with life and not paying personal and collective attention to specious attacks; still others appear to believe that righteous force is the best way to prevail, and so they dedicate themselves to retaliation and the gathering of power in its different forms. This study suggests another way, based on the transformation of the hate and pain through a collective holding process,

known as container-building. Venturing together on the underused pathways that connect mind, heart, spirit, body, and community, even those with the most seemingly hostile and irreconcilable behaviors can, under certain conditions, soften, open, and yield. It is my hope that this study contributes insights and tools to that unfolding. The time is now.

APPENDIX A
OBSERVATION FORMATS

Group Dynamics

Sharing of personal testimony	Shift in inter-trainee dynamics	Role of enhanced understanding of larger context issues

Attitudes about self and larger system

shift in self concept	shift in attitudes about family	shift in attitudes re. community	shift in belief system

Attitudes about Change

Attitudes or behaviors that foster flexibility	Attitudes or behaviors that indicate resistance to change	Examples drawn from trainees' experience in Central America

Safety

how safety was fostered or weakened in the group	how inner group bonds were reinforced or undermined	how bonds between facilitator and group were created

APPENDIX B
INTERVIEW FORMAT WITH PSYCHOTHERAPISTS AND EDUCATORS

1.- What are your thoughts about the applicability of diagnostic criteria of PTSD outside of the United States, given its emergence as a response to the reality of Vietnam veterans?

2.- What is your experience with using an educational setting for psychotherapeutic purposes? Is there a rationale for refraining from therapeutic intervention in an educational setting? If so, what is it?

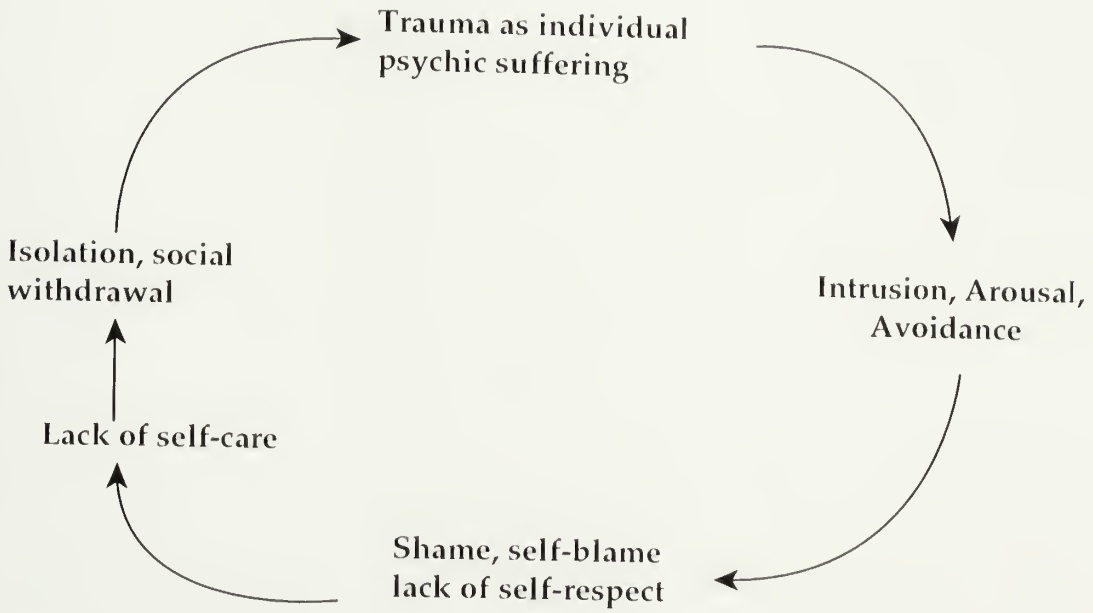
3.- What are your thoughts about the viability of a combined role of educator/therapeutic guide? Does the educational/therapeutic guide need prior experience with personal psychological trauma healing? How do you view the role of "warrior-veteran"?

4.- Is there something unique about the therapeutic relationship with trauma survivors? What are your recommendations regarding personal disclosure, affinity, boundaries, neutrality?

4.- How could secondary trauma be prevented for those not professionally trained as mental health practitioners? Is there a role for para-professionals? What might a training prevention module include?

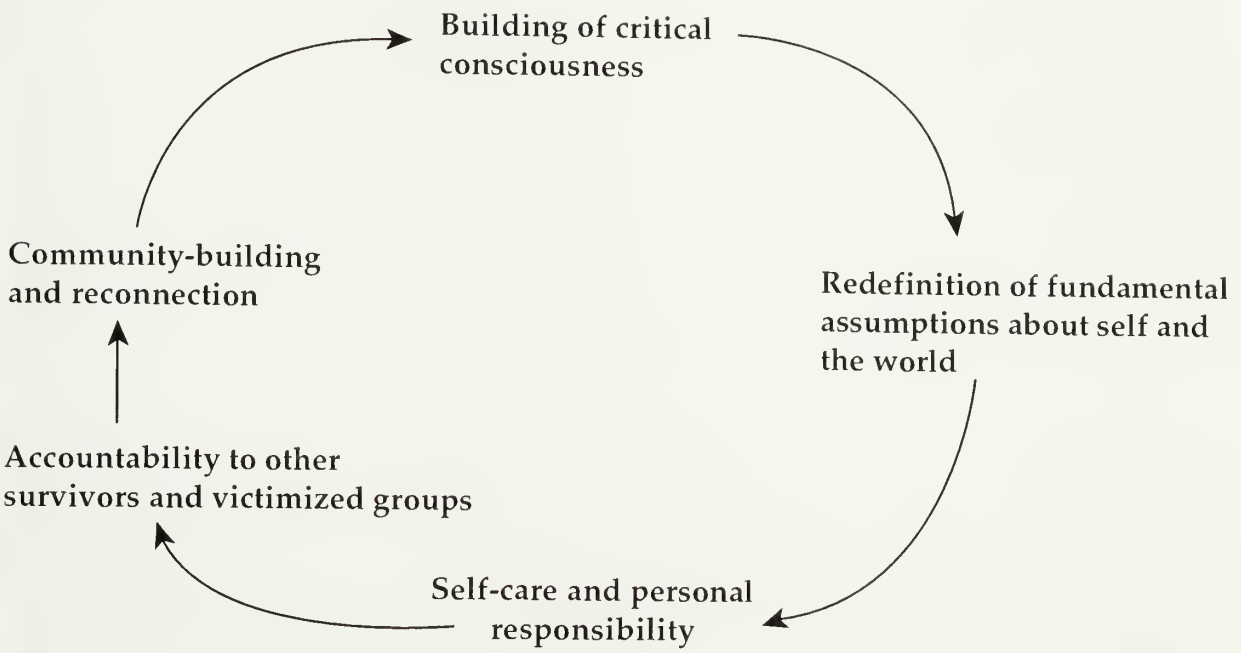
APPENDIX C
INTRAPSYCHIC MODEL OF PSYCHOLOGICAL TRAUMA

Intrapsychic Model

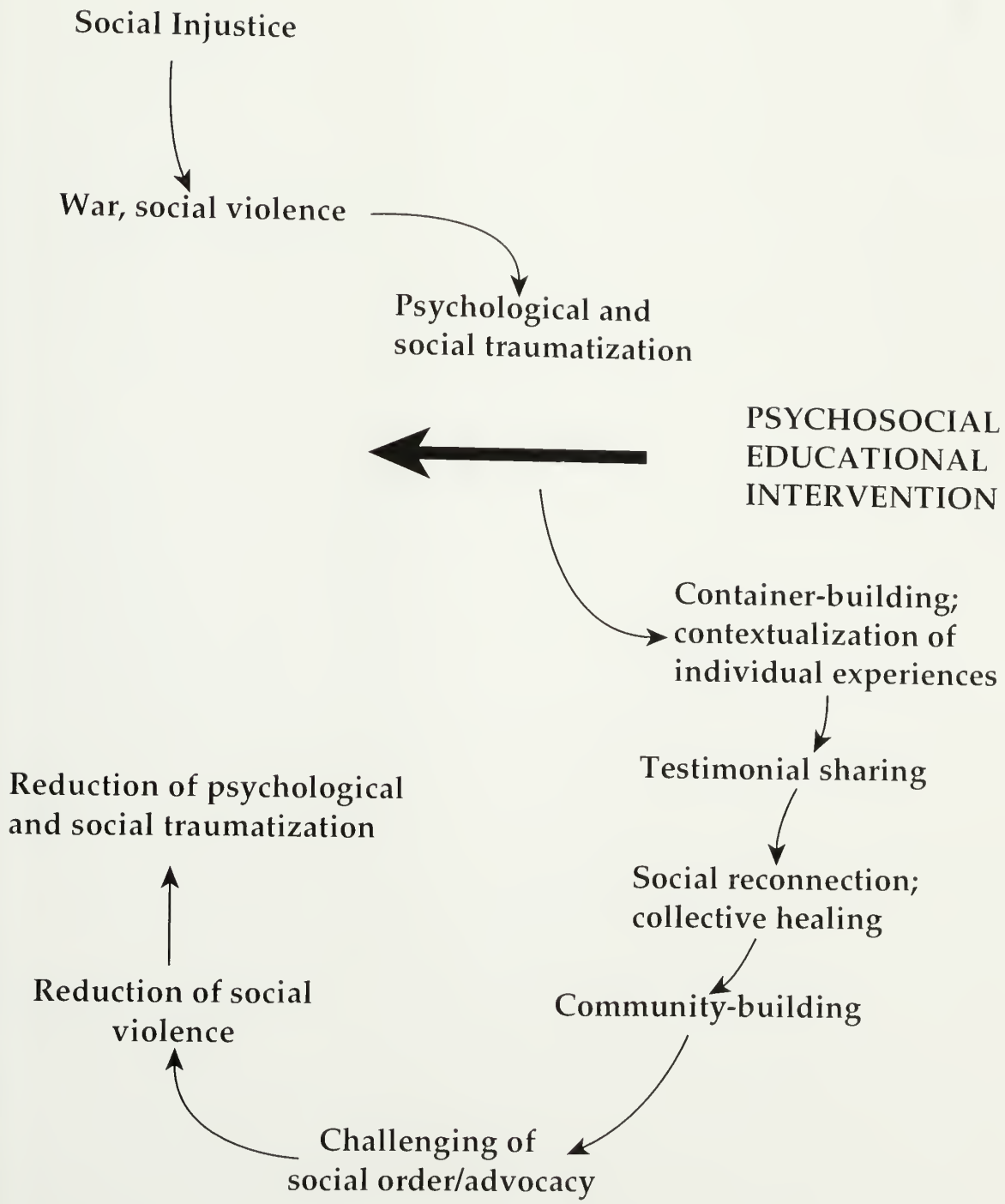


APPENDIX D
PSYCHOSOCIAL MODEL OF PSYCHOLOGICAL TRAUMA

Psychosocial Model



APPENDIX E
PSYCHOSOCIAL EDUCATIONAL INTERVENTION MODEL



BIBLIOGRAPHY

ACISAM. (1989). "La psicología comunitaria como terapéutica social en El Salvador." San Salvador: Author.

Agger, I. (1989). "Sexual torture of political prisoners: an overview." *Journal of Traumatic Stress* , 2: 305-318.

Agger, I. (1994). *The Blue Room: Trauma and Testimony among Refugee Women, A Psycho-Social Exploration.* London: Zed Books.

American Psychiatric Association. (1980). Diagnostic and Statistical Manual of Mental Disorders. Washington, D.C.: Author.

American Psychiatric Association. (1987). Diagnostic and Statistical Manual of Mental Disorders,Third Edition, Revised. Washington, D.C.: Author.

American Psychiatric Association (1994). Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Washington, D.C.: Author.

Anonymous (1989). "Talleres Integrales con niños afectados por el terrorismo de estado: salud mental y derechos humanos o creando un espacio alternativo desde los margenes." Unpublished Manuscript: Buenos Aires.

Antonovsky, A. (1987). *Unraveling the Mystery of Health.* San Francisco: Jossey-Bass.

Apfel, R. & Simon, B. (1995). "On Psychosocial Intervention for Children: Some Minders and Reminders." *UNICEF Review Article,* New York.

Arditti, R. and Lykes, M.B. (1991)."The Disappeared Children of Argentina: The Work of the Grandmothers of Plaza de Mayo,"in M. Agosin, (Ed.),*Women, Children and Human Rights in Latin America..* San Francisco: Westview Press.

Armstrong, K., O'Callahan, W., & Marmar, C. (1991). "Debriefing Red Cross Disaster Personnel: The Multiple Stressor Debriefing Model." *Journal of Traumatic Stress,* Vol. 4, No. 4.

Aron, A. Testimonio, (1992). "A Bridge between Psychotherapy and Sociotherapy." *Women and Therapy,* 13 (1-2).

Arredondo, P., Orjuela, E. and Moore, L.(1989). "Family Therapy with Central American War Refugee Families." *Journal of Strategic and Systemic Therapies,* 8 (2).

ASECSA. (1991). "El Duelo." Chimaltenango: Author.

ASECSA. (1991). "El Dibujo." Chimaltenango: Author.

ASECSA. (1991). "El Juego y La Creatividad." Chimaltenango: Author.

Ayalon, O. (1982). "Teaching children strategies for coping with stress." Bereavement care, 2: 2-3.

Ayalon, O. (1988). "Community mental care for victims of terrorist activities," in M. Lahad & A. Cohen , (Eds.), *Community stress prevention* (lst edition). Kiriat Shmona, Israel: The Community Stress Centre.

Bar-On, D. (1992). "A Testimony on the Moment Before the (Possible) Occurrence of a Massacre: On a Possible Contradiction Between the Ability to Adjust Which Means Mental Health and the Maintaining of Human Moral Values." *Journal of Traumatic Stress,* 5, (2).

Baron, N. (1994a). *A Little Elephant finds his Courage.* Sri Lanka: Tharanjee Prints.

Baron, N. (1994b). "Report of Psycho-Social Needs Assessment: The Voice of Internally Displaced People in the non-conflict area of Sri Lanka." (Unpublished Manuscript). Colombo: International Federation of Red Cross.

Barudy, J. (1990). "Tortura, Exilio y Salud Mental: Nuestra Conceptualización," in *Tortura: Aspectos Médicos, Psicológicos y Sociales. Prevención y Tratamiento.* Santiago: CODEPU.

Bass, E. & Davis, L. (1988). *The Courage to Heal.* New York: Harper & Row.

Becker, D. (1995). "The Deficiency of the Concept of Posttraumatic Stress Disorder When Dealing with Victims of Human Rights Violations," in R. Kleber, C. Figley, & B. Gersons, (Eds.),*Beyond Trauma.* New York: Plenum Press.

Becker, D., Castillo, M. I., Gómez, E., Kovalskys, J., & Lira, E. (1989). "Subjectivity and Politics: The psychotherapy of extreme traumatization in Chile." *International Journal of Mental Health,* 18 (2): 80-97.

Bettelheim, B. (1943). "Individual and mass behavior in extreme situations." *Journal of Abnormal and Social Psychology,* 38: 417-452.

Bograd, M. (1991). *Feminist Approaches for Men in Family Therapy.* New York: Haworth Press.

Boothby, N. (1992). "Children of War: Survival as a Collective Art." In *The Psychological Well-Being of Refugee Children: Research, Practice and Policy Issues.* Geneva: International Catholic Child Bureau.

Boszormenyi-Nagy & Sparks (1973). *Invisible Loyalties.* New York: Harper Row.

Bowen, D., Carscadden, L., Beighle, K., and Fleming, I. (1992). "Post-Traumatic Stress Disorder among Salvadoran Women: Empirical Evidence and Description of Treatment." *Women and Therapy,* 13 (1-2).

Bracken, P., Giller, J. & Summerfield, D. (1995). "Psychological responses to war and atrocity: the limitations of current concepts." *Social Science and Medicine,* 40 (8): 1073-1082.

Bracken, P. (1993). "Post-empiricism and psychiatry: meaning and methodology in cross-cultural research." *Social Science and Medicine,* 36 (3): 265-272.

Brody, E. "The Mental Health and Well-being of Refugees: Issues and Directions. " Chapter 3 in unknown source.

Brown, E.M. & Shanahan, K. (in press). "A New Story of Healing: breaking through silences of the 'double losses' for the second and third generations of holocaust families." Manuscript in revision for American Journal of Orthopsychiatry.

Brown, M.L. (1983). *The Unfolding Self: Psychosynthesis and Counseling.* San Rafael, CA: Psychosynthesis Press.

Brown, L. (1994). Boundaries in Feminist Therapy: A Conceptual Formulation. *Women and Therapy,* 15.

Browne, I. (1990). "Psychological Trauma, or Unexperienced Experience." *ReVision*, 12(4): 21.

Canino, I. & Canino, G. (1980). "The impact of stress on the Puerto Rican migrant: Treatment Considerations." *American Journal of Orthopsychiatry*, 50 (3): 535-542.

Caplan, P.J. (1985). *The Myth of Women's Masochism*. New York: Dutton.

Catherall, D. & Lane, C. (1992). "Warrior Therapist: Vets Treating Vets." *Journal of Traumatic Stress*, Vol. 5, No. 1.

CEDDI. (1992). *Psicoterapias, Trabajo Comunitario y Talleres. Dossiers Bibliográficos en Salud Mental y Derechos Humanos*. Buenos Aires: Author.

Chakraborty, A. (1991). "Culture, colonialism, and psychiatry." *Lancet* 337: 1204-1207.

Cienfuegos, A.J. and Monelli, C. (1983)."The Testimony of Political Repression as a Therapeutic Instrument." *American Journal of Orthopsychiatry* 53 (1): 43-51.

Cohn, I. (1988). "The Project on Children and War." Center for the Study of Human Rights, Columbia University, and Center for International Development Research, Duke University.

Contreras, C. & Corvalán, C. (1990). "Taller terapéutico: Una Experiencia de Trabajo Grupal en Pacientes Sometidos a Situaciones de Violencia Extrema," in CODEPU. *Tortura: Aspectos Médicos, Psicológicos y Sociales. Prevención y Tratamiento.* Santiago: CODEPU.

Cooper, S. (1992). Anthropological Impressions of Koach: Participant Observations. *Journal of Traumatic Stress*, Vol. 5, No. 2: 247-264.

Corvalan, C. (1990). "Experiencia de Trabajo en el Centro Psicosocial de Frankfurt, Alemania Federal," in CODEPU. *Tortura: Aspectos Médicos, Psicológicos y Sociales. Prevención y Tratamiento.* Santiago: CODEPU.

Creamer, M. (1995). "A Cognitive Processing Formulation of Posttrauma Reactions,"in R. Kleber, C. Figley, & B. Gersons, (Eds.),*Beyond Trauma. Cultural and Societal Dynamics*. New York: Plenum Press.

Danieli, Y. (1988). "Treating survivors and children of survivors of the Nazi Holocaust," in F. Ochberg (Ed.), *Post-traumatic therapy and victims of violence.* New York: Brunner/Mazel.

Dawes, A. (1992). "Psychological Discourse about political violence and its effects on children." Paper prepared for the meeting on The Mental Health of Refugee Children Exposed to Violent Environments, Refugee Studies Programme, University of Oxford.

Dyregrov, A. & Mitchell, J. (1992). "Work with Traumatized Children - Psychological Effects and Coping Strategies." *Journal of Traumatic Stress* 5 (1).

Eisenbruch, M. (1984). "Cross-cultural aspects of bereavement: II. Ethnic and cultural variations in the development of bereavement practices." *Culture, Medicine and Psychiatry,* 8: 315-347.

Eisenbruch, M. (1991). "From posttraumatic stress disorder to cultural bereavement: Diagnosis of Southeast Asian refugees." *Social Science and Medicine,* 33: 673-680.

Eisenbruch, M. (1992). "Commentary. Toward a culturally sensitive DSM: cultural bereavement in Cambodian refugees." *Journal of Nervous and Mental Disease,* 180: 8-10.

Epstein, S. (1985). The implications of cognitive-experiential self-theory for research in social psychology and personality. *Journal of the Theory of Social Behavior*, 14, 283-310.

Epstein, S. (1990). "Beliefs and symptoms in maladaptive resolutions of the traumatic neurosis," in D. Ozer, J.M. Healy & A. J. Stewart (Eds.), *Perspectives on Personality, Vol. 3.* London: Jessica Kingsley, Publishers.

Esterio, M., San Román, L. & Almarza, M. T. (1990). "Grupo Terapéutico de Reencuentro," in *Tortura: Aspectos Médicos, Psicológicos y Sociales. Prevención y Tratamiento.* Santiago: CODEPU.

Eth, S. (1992). "Ethical Challenges in the Treatment of Traumatized Refugees." *Journal of Traumatic Stress,* Vol. 5, No. 1.

Fabrega, H. (1987). "Psychiatric diagnosis: A cultural perspective." *Journal of Nervous and Mental Disease,* 175: 383-394.

Farhood, L., Zurayk, M.C., Saadeh, F., Meshefedjian, G. & Sidani, T. (1993). "The Impact of War on the physical and mental health of the family: the Lebanese Experience." *Social Science Medicine,* 36 (12): 1555-1567.

Figley, C. R. (1978). *Stress Disorders among Vietnam veterans: Theory, research, and treatment.* New York: Brunner/Mazel.

Figley, C. R. & S. Leventman, Eds. (1980). *Strangers at home: Vietnam veterans since the war.* New York: Praeger.

Figley, C. R. (1985). *Trauma and its wake.* New York: Brunner/Mazel.

Fischman, Y. (1991). "Interacting with trauma: Clinician's responses to treating psychological aftereffects of torture and political repression."*American Journal of Orthopsychiatry,* 6(2): 179-185.

Forbes, D., Creamer, M., & Rycroft, P. (1994). "Eye movement desensitization and reprocessing." *Journal of Behavior Therapy and Experimental Psychiatry.* Vol. 25 (2): 113-120.

Frank, E., Turner, S., Stewart, B.D., Jacob, M. & West, D. (1981). "Past psychiatric symptoms and the response to sexual assault." *Comprehensive Psychiatry,* 22: 479-487,

Freire, P. (1972). *Pedagogy of the Oppressed.* New York: Herder & Herder.

Freire, P. (1973). *Education for Critical Consciousness.* New York: Continuum.

Freire, P. & Macedo, D. (1995). "A Dialogue: Culture, Language, and Race." *Harvard Educational Review,* Vol. 65, No. 3.

Gaines, A. (ed.) (1992). *Ethnopsychiatry. The Cultural Construction of Professional and Folk Psychiatries.* New York: State University of New York Press.

Garbarino, J. (1982). "Sociocultural Risk: Dangers to Competence." In Kopp & Krakow (Eds.). *The Child: Development in a Social Context.* Lexington: Addison-Wesley.

Garbarino, J. (1990). "Children and youth in war zones: coping with the consequences." Testimony prepared for the U.S. Senate Committee on Human Resources, Subcommittee on Children, Family, Drugs, and Alcoholism, Washington, D.C.

Garbarino, J., Kostelny, K. & Dubrow, N. (1991). *No Place to Be a Child. Growing up in a War Zone.* Lexington Books: Lexington.

Giller, E. L. (ed.) (1990). *Biological Assessment and Post-traumatic Stress Disorder.* Washington, D.C.: American Psychiatric Press.

Glendinning, C. (1994). *My Name is Chellis & I'm in Recovery from Western Civilization.* Boston: Shambala.

Goldstein, A. (1994). "Eye movement desensitization and reprocessing for panic disorder: A case series." *Journal of Anxiety Disorders.* Vol. 8(4): 351-362.

Goleman, D. (1995). *Emotional Intelligence.* New York: Bantam Books.

Gonsalves, C., Torres, T. Fischman, Y., Ross, J., Vargas, M. (1993). "The Theory of Torture and the Treatment of Its Survivors: An Intervention Model." *Journal of Traumatic Stress,* Vol. 6, No. 3.

Green, B.L., Wilson, J.P., & Lindy, J.D. (1985). "Conceptualizing posttraumatic stress disorder: A psychosocial framework," in C.R. Figley (Ed.),*Trauma and its wake: the study and treatment of posttraumatic stress disorder.* New York: Brunner/Mazel.

Greenspan, M. (1983). *A New Approach to Women and Therapy.* New York: McGraw Hill.

Haley, S. A. (1974). "When the patient reports atrocities." *Archives of General Psychiatry,* 30: 191-196.

Harvey, M. (1996). "An Ecological View of Psychological Trauma and Trauma Recovery." *Journal of Traumatic Stress,* Vol. 9, No. 1: 3-23.

Heggenhougen, H.K. (1995). "Editorial: The Epidemiology of Functional Apartheid and Human Rights Abuses." *Social Science and Medicine,* 40 (3): 281-284.

Herbst, P.K.R.(1992). "From Helpless Victim to Empowered Survivor: Oral History as a Treatment for Survivors of Torture." *Women and Therapy* 13 (1-2).

Herman, J. (1992a). *Trauma and Recovery.* New York: Basic Books.

Herman, J. (1992b). "Complex PTSD: A Syndrome in Survivors of Prolonged and Repeated Trauma." *Journal of Traumatic Stress*, Vol. 5, No. 3.

Horowitz, M.J. (1974). "Stress response syndromes: Character style and dynamic psychotherapy." *Archives of General Psychiatry* 31: 768-781.

Horowitz, M.J. (1976). *Stress response syndromes*. New York: Jason Aronson.

Horowitz, M.J. (1986). Stress response syndromes. *Hospital and Community Psychiatry*. Vol. 37, No. 3

Janoff-Bulman, R. (1992). *Shattered Assumptions: Towards a New Psychology of Trauma*. NY: The Free Press.

Jareg, E. (1995a). "Main Guiding Principles for the development of psychosocial intervention for children affected by war." Paper prepared for ISCA Workshop, Stockholm, Sweden.

Jareg, E. (1995b)."Basic Therapeutic Actions: Helping Children, Young People and Communities to cope through empowerment and participation." Paper prepared for ISCA Workshop, Stockholm, Sweden.

Johnson, D.R. (1987). "The Role of the Creative Arts Therapies in the Diagnosis and Treatment of Psychological Trauma." *The Arts in Psychotherapy*, 14: 7-13.

Kardiner, A. (1941). *The traumatic neuroses of war*. New York: Hoeber.

Keane, T.M., Fairbank, J.A., Caddell, R.T., Zimering, R.T., & Bender, M.E. (1985). "A behavioral approach to assessing and treating PTSD in Vietnam veterans," in C.R. Figley (Ed.) *Trauma and its wake*. New York: Brunner/Mazel.

Keilson, H. (1992). *Sequential Traumatization in children*. Jerusalem: Magnes Press, Hebrew University.

Kirmayer, L. (1989). "Cultural variation in the respones to psychiatric disorders and emotional distress." *Social Science and Medicine*, 29: 327-339.

Kleber, R., Figley, C., & Gersons, B. (Eds.). (1995). *Beyond Trauma. Cultural and Societal Dynamics.* New York: Plenum Press.

Kolb, L.C. (1988). A Critical Survey of Hypotheses Regarding Post-traumatic Stress Disorders in Light of Recent Research Findings. *Journal of Traumatic Stress,* 1(3), 291-304.

Kolb, L.C. (1993). "The Psychobiology of PTSD: Perspectives and Reflections on the Past, Present, and Future." *Journal of Traumatic Stress,* Vol. 6, No. 3.

Kozaric-Kovacic, D., Folnegovic-Smalc, V., Skrinjaric, J., Szajnberg, N., Marusic, A. (1995). Rape, Torture and Traumatization of Bosnian and Croatian Women: Psychological Sequelae. *American Journal of Orthopsychiatry,* 65(3): 429-445.

Krippner, S. (1995). "A Cross-Cultural Comparison of four healing models." *Alternative Therapies,* 1 (1): 21-29.

Krystal, H. (1978). "Trauma and affects." *Psychoanal. Study Child,* 33:81-115.

Lifton, R. J. (1976)."Advocacy and corruption in the healing professions." *International Review of Psychoanalysis,* 3: 385-398.

Lifton. R. J. (1982). The psychology of the survivor and the death imprint. *Psychiatric Annals,* 12 (11): 1011-1020.

Light, D. (1992). "Healing Their Wounds: Guatemalan Refugee Women as Political Activists. Refugee Women and Their Mental Health. Diagnostic Studies Across Cultures." *Women and Therapy,* 13 (1-2).

Lindy, J.D., Green, B.L., Grace, M.C., MacLeod, J.A., & Spitz, L. (1988). *Vietnam: A Casebook.* New York: Brunner/Mazel.

Lira Kornfeld, E. (1995) "The Development of Treatment Approaches for Victims of Human Rights Violations in Chile," in R. Kleber, C. Figley, & B. Gersons, (Eds.), *Beyond Trauma. Cultural and Societal Dynamics.* New York: Plenum Press.

Lira, E. & Weinstein, E. (Eds.). (1984).*Psicoterapia y represión política.* Mexico City: Siglo XXI.

Liwski, N. (1990). "La Comunidad y la Asistencia Terapéutica en Derechos Humanos," in CODEPU, *Tortura: Aspectos Médicos, Psicológicos y Sociales. Prevención y Tratamiento.* Santiago: CODEPU.

Lykes, M.B. "Children in the Storm: Psychosocial trauma in Latin America." Unpublished Manuscript.

Lykes, M.B. (1992). "Guatemalan Indian Children and the Sociocultural Effects of Government-Sponsored Terrorism." *Social Science and Medicine,* 34(5): 533-548.

Lykes, M.B. (1994). "Terror, silencing, and children: International, multidisciplinary collaboration with Guatemalan Maya communities." *Social Science and Medicine.* 38(4): 543-552.

Lykes, M.B., Brabeck, M., Ferns, T., & Radan, A. (1993). "Human Rights and Mental Health among Latin American women in situations of state-sponsored violence." *Psychology of Women Quarterly,* 17: 525-544.

Macksoud, M. (1993). *Helping Children Cope with the Stresses of War. A Manual for Parents and Teachers.* New York: UNICEF.

Martín-Baro, I. (1982). "Un psicólogo social ante la guerra civil en El Salvador." *Revista de la Asociación Latinoamericana de Psicología Social,* 2: 91.

Martín-Baró, I. (1988). "Guerra y trauma psicosocial del niño Salvadoreño." Ponencia del Seminario-Taller, Tratamiento y recuperación post-traumático del niño, San Salvador.

Martín-Baró, I. (1994). *Writings for a Liberation Psychology.* Cambridge: Harvard University Press.

Martir Hidalgo, J. (1990). *Guerra y despersonalización: efecto psicosocial del conflicto armado en los sectores populares de El Salvador.* San Salvador: ACISAM.

McCann, I.L. & Pearlman, L.A. (1990). "Vicarious traumatization: a framework for understanding the psychological effects of working with victims." *Journal of Traumatic Stress,* 3(1), 131-150.

McCann & Pearlman (1991). *Psychological Trauma & the adult survivor: theory, therapy and transformation.* NY: Brunner/Mazel.

Melville, M. & Lykes, M.B. (1992). "Guatemalan Indian children and the sociocultural effects of terrorism." *Social Science and Medicine* , 34(5): 533-548.

Merriam. S. (1991). *Case Study Research in Education*. San Francisco: Jossey-Bass.

Merwin, M. & Smith-Kurtz, B. (1987). "Healing of the Whole Person," in F. M. Ochberg (Ed.),*Post-Traumatic Therapy and Victims of Violence*. New York: Brunner/Mazel.

Millon, T. & Everly, G. (1985). *Personality and its Disorders*. New York: John Wiley & Sons.

Mindell, A. (1992). *The Leader as Martial Artist*. San Francisco: Harper.

Mindell, A. & Mindell, A. (1992). *Riding the Horse Backwards: Process Work in Theory and Practice*. New York: Penguin Arkana.

Mollica, R. (1989) Khmer Mental Health: Individual, Community, and Political Solutions. *Southeast Asian Refugees.*

Mollica, R., Wyshak, G., Lavelle, J., Truong, T., Tor, S., and Yang, T. (1990). "Assessing Symptom Change in Southeast Asian Refugee Survivors of Mass Violence and Torture." *American Journal of Psychiatry* , 1: 147.

Mollica, R., Caspi-Yavin, Y., Bollini, P., Truong, T., Tor, S., Lavelle, J. (1992). "The Harvard Trauma Questionnaire. Validating a Cross-Cultural Instrument for Measuring Torture, Trauma, and Posttraumatic Stress Disorder in Indochinese Refugees." *The Journal of Nervous and Mental Disease*, 180: 111-116.

Morera, C. & Taboada, A. (1985). "Grupo Terapéutico de Adultos." Unpublished Manuscript. Buenos Aires: Movimiento Solidario de Salud Mental.

Munroe, J. F. (1993). "Ethical Implications of Secondary Trauma in Therapists."(Hand-out, ISTSS 9th annual meeting). Boston: VA OPC.

Munroe, J. F. & Bitman, D. B. (1994). "Understanding PTSD: An Introduction to the Treatment of Trauma: A Ten Session Psychoeducational Approach." Unpublished. Boston: Department of Veterans Affairs Outpatient Clinic.

Munroe, J., Shay, J., Fisher, L., Makary, C., Rapperport, K., & Zimering, R. (1995). "Preventing Compassion Fatigue: A treatment team model," in C. R. Figley, (Ed.), *Compassion Fatigue: Coping with secondary tranmatic stress disorder in those who treat the tranmatized.* New York: Brunner/Mazel.

Ochberg, F. & Fotjik, K. (1984). "A comprehensive mental health clinical services program for victims." *American Journal of Social Psychiatry,* 4: 12-23.

Ochberg, F. (Ed.). (1988). *Post-traumatic therapy and victims of Violence.* New York: Brunner/Mazel.

Ochberg, F. (1991). "Post-traumatic therapy." *Psychotherapy,* 28: 5-16.

OCISAM. (1986). "Programa de capacitación en Salud Mental Comunitaria para la atención de las zonas de escasos recursos pertenencientes al Departamento de San Salvador y que se encuentran en estado de desastre." San Salvador: Author.

O'Donohue & Elliott, A. (1992). The Current Status of Post-Traumatic Stress Disorder as a Diagnostic Category: Problems and Proposals. *Journal of Tranmatic Stress,* Vol. 5, No. 3.

Ofri, I., Solomon, Z. & Dasberg, H. (1995). "Attitudes of Therapists Toward Holocaust Survivors." *Journal of Tranmatic Stress.* Vol. 8, No. 2.

Ogden, J. (1995)."Psychosocial theory and the creation of the risky self." *Social Science and Medicine,* 40(3): 409-415.

Pallmeyer, T. P., Blanchard, E. B., & Kolb, L. C. (1986). "The psychophysiology of combat-induced posttraumatic stress disorder in Vietnam veterans." *Behavioral Research Therapy,* 24: 645-52.

Peterson, K.C., Prout, M.F. & Schwarz, R.A. (1993). *Post-Traumatic Stress Disorder: A Clinician's Guide.* New York: Plenum Press.

Punamaki, R. (1989). "Political violence and mental health." *International Journal of Mental Health,* 17: 3-15.

Ressler. E. (1993).*Children in War: A guide to the Provision of Services.* New York: UNICEF.

Roberts, W. R., Penk, W. E., Gearing, M. L., Robinowitz, R., Dolan, M. P., & Patterson, E. T. (1982). "Interpersonal problems of Vietnam combat veterans with symptoms of posttraumatic stress disorder." *Journal of Abnormal Psychology*, 91 (6): 444-450.

Rojas, P. (1990). "Terapia al Torturado: Una Reflexión de una Práctica Humana," in *Tortura: Aspectos Médicos, Psicológicos y Sociales. Prevención y Tratamiento.* Santiago: CODEPU.

Roth, S. & Newman, E. (1991). "The Process of Coping with Sexual Trauma." *Journal of Traumatic Stress*, Vol. 4, No. 2

Roth, S. & Baston, R. (1993). "The Creative Balance: The Therapeutic Relationship and Thematic Issues in Trauma Resolution." *Journal of Traumatic Stress*, Vol. 6, No. 2.

Schwartz, H. J. (Ed.) (1984). *Psychotherapy of the combat veteran.* New York: Medical and Scientific Books.

Shapiro, F. (1994). "Eye movement desensitization and reprocessing: Treating trauma and substance abuse." *Journal of Psychoactive Drugs.* Vol. 26(4): 379-391.

Solomon, Z., Bleich, A., Shoham, S., Nardi, C. & Kotler, M. (1992). "The "Koach" Project for Treatment of Combat-Related PTSD: Rationales, Aims, and Methodology." *Journal of Traumatic Stress*, Vol. 5, No.2.

Southard, E. (1919). *Shell Shock and Neuropsychiatry.* Boston: W.M. Leonard.

Srinivasen, L. (1990).*Tools for Community Participation.* New York: PROWWESS/ UNDP.

Stamm, H. B. (1996). *Secondary Traumatic Stress.* New York: Sidran.

Summerfield, D. (1995). "Addressing Human Response to War and Atrocity: Major Challenges in Research and Practices and the Limitations of Western Psychiatric Models," in R. Kleber, C. Figley, & B. Gersons, (Eds.),*Beyond Trauma.* New York: Plenum Press.

Sykes Wylie, M. (1996). "It's a Community Affair." *The Family Therapy Networker*, March/April 1996.

Talbot, A., Manton, M. & Dunn, P. (1992). "Debriefing the Debriefers: An Intervention Strategy to Assist Psychologists After a Crisis." *Journal of Traumatic Stress*, Vol. 5, No. 1.

Timmel, S. & Hope, A. (1984). *Training for Transformation. A Handbook for Community Workers*. Gweru: Mambo Press.

UNICEF. (1990). *Training Manual for Helping Children in Situations of Armed Conflict*. Colombo: Author.

UNICEF. (1992). "Survivors: Rehabilitation of Children in Armed Conflict." New York: Author.

USAID. (1993). "Program for rural workers." San Salvador: Office of Education and Training.

Valentine, P. (1995). "Traumatic incident reduction: A review of a new intervention." *Journal of Family Psychotherapy*. Vol. 6(): 73-78.

van der Kolk, B. A. (1987). *Psychological Trauma*. Washington: American Psychiatric Press.

van der Kolk, B. A. (1988). "The biological response to trauma," In F. Ochberg (Ed.), *Post-traumatic therapy and victims of violence*. New York: Brunner/Mazel.

van der Kolk, B. A., Krystal, H., & Greenberg, M. S. (1984). "Post-traumatic stress disorder as a biologically based disorder: Implications of the animal model of inescapable shock," in B. A. van der Kolk (Ed.), *Post-traumatic stress disorder: Psychological and biological sequelae*. Washington, D.C.: American Psychiatric Press.

van der Kolk, B. A., Greenberg, M. S., Boyd, H., & Krystal, J. (1985). "Inescapable shock, neurotransmitters and addiction to trauma. Towards a psychobiology of posttraumatic stress. " *Biological Psychiatry* , 20: 314-325.

van der Kolk, B. A., & Greenberg, M. S. (1987). "The psychobiology of the trauma response: Hyperarousal, constriction, and addiction to traumatic exposure," in B.A. van der Kolk (Ed.), *Psychological Trauma*, Washington, D. C.: American Psychiatric Press.

van Kampen, M., Watson, C. G., Tilleskjor, C., Kucala, T., & Vassar, P. (1986). "The definition of posttraumatic stress disorder in alcoholic Vietnam veterans: Are the DSM-III criteria necessary and sufficient?"*Journal of Nervous and Mental Disease*, 174 (3): 137-143.

Vidal, M. (1990a). "Lo igual y lo distinto en los problemas psicopatológicos ligados a la represión política." in *Tortura: Aspectos médicos, psicológicos y sociales. Prevención y Tratamiento.* Santiago: CODEPU.

Vidal, M. (1990b). "Experiencia de Trabajo de CINTRAS," in *Tortura: Aspectos médicos, psicológicos y sociales. Prevención y Tratamiento.* Santiago: CODEPU.

Walker, L. (1979). *The Battered Woman.* New York: Harper & Row.

Walker, L. (1989). "Psychology and the violence against women." *American Psychologist* , 44: 695-702.

Westermeyer, J. (1989). "Cross-cultural care for PTSD: Research, training and service needs for the future." *Journal of Traumatic Stress,* 2: 515-536.

Wilson, J. P. (1989). *Trauma, Transformation and Healing: an Integrative Approach to Theory, Research, and Post-Traumatic Therapy.* New York: Brunner/Mazel.

Wilson, J. P. & Krauss, G. E. (1985). "Predicting posttraumatic stress disorders among Vietnam veterans," in W. E. Kelly (Ed.), *Post-traumatic stress disorder and the war veteran patient,* New York: Brunner/Mazel.